# Prescription Package

For authorized registered nurse and registered psychiatric nurse prescribing of opioid agonist treatment medications

This document collates examples of the Controlled Prescription Program forms that RNs and RPNs will likely write as part of their scope of practice.

The protocols for inductions, dose decreases, or restarts are based upon those outlined in the Decision Support Tool: Registered Nurse and Registered Psychiatric Nurse Prescribing of Buprenorphine/naloxone and Decision Support Tool: For RN and RPN Prescribing of Methadone or Slow-release Oral Morphine for Continuations, Titrations, or Restarts.

Note that the prescriptions included in this document are for example purposes to help guide prescription writing and emphasize best practices. In clinical practice, prescriptions should be written according to the needs of the patient.

## Additional resources

The following modules contain education on how to write prescriptions for scenarios within RNs and RPNs' scope of practice:

- Module 11: Buprenorphine/naloxone—How to Write a Prescription
- Module 14: Methadone—How to Write a Prescription
- Module 16: Slow-release Oral Morphine

Prescription Checklist includes a checklist of items included on prescriptions

# Table of contents

Buprenorphine/naloxone

# Example prescription of a micro-dosing induction with carries

Potential scenarios as per RN/RPN scope of practice:
Inductions or restarts

10-day prescription for a micro-dosing induction, titrating up to a daily dose of 12mg/3mg buprenorphine/naloxone, with an additional 2 x 2mg/0.5mg for days 8–10, as needed:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 28 (DAY) 06 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — VOID IF ALTERED

Buprenorphine/naloxone 2mg/0.5mg

**QUANTITY (IN UNITS)**

86.5mg (NUMERIC) | Eighty-six and one half milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 29 (DAY) 06 (MONTH) 21 (YEAR) **END DATE:** 08 (DAY) 07 (MONTH) 21 (YEAR)

**TOTAL DAILY DOSE**
Refer to Directions
NUMERIC / ALPHA mg/day

**NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION**
Nil (NUMERIC) Nil (ALPHA)

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Buprenorphine/naloxone sublingual tablets micro-dosing induction
Day 1: 0.5mg twice a day
Day 2: 0.5mg three times a day
Day 3: 1mg twice a day
Day 4: 2mg twice a day
Day 5: 2mg three times a day
Day 6: 4mg three times a day
Day 7: 12mg once daily
Day 8–10: 12mg once daily and up to 2 x 2mg/0.5mg tabs as needed
Dispense all doses in blister packaging
Release June 28 for carry, no witness

**NO REFILLS PERMITTED**
**VOID AFTER 5 DAYS** UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898 **PRESCRIBER ID**

00000000005 **FOLIO**

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# Example prescription of a micro-dosing induction with carries (cont.)

Directions for use, indication for therapy, or special instructions text:

Buprenorphine/naloxone sublingual tablets micro-dosing induction
Day 1: 0.5mg twice a day
Day 2: 0.5mg three times a day
Day 3: 1mg twice a day
Day 4: 2mg twice a day
Day 5: 2mg three times a day
Day 6: 4mg three times a day
Day 7: 12mg once daily
Day 8–10: 12mg once daily and up to 2 x 2mg/0.5mg tabs as needed
Dispense all doses in blister packaging
Release June 28 for carry, no witness

Buprenorphine/naloxone

# Example prescription of Day 1 and Day 2 of a traditional induction with take-home dosing

Potential scenarios as per RN/RPN scope of practice:
Inductions or restarts

2-day prescription for days 1 and 2 of a traditional induction:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 28 DAY | 06 MONTH | 21 YEAR

**PATIENT NAME** — FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** — STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 DAY | 09 MONTH | 88 YEAR

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

Buprenorphine/naloxone 2mg/0.5mg

**QUANTITY (IN UNITS)**

16mg (NUMERIC) | Sixteen milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 29 DAY | 06 MONTH | 21 YEAR — **END DATE:** 29 DAY | 06 MONTH | 21 YEAR

**TOTAL DAILY DOSE**
Refer to Directions
NUMERIC | ALPHA | mg/day

**NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION**
Nil (NUMERIC) | Nil (ALPHA)

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Buprenorphine/naloxone sublingual tablets
Target dose is 12mg/3mg buprenorphine/naloxone, plus 2 x 2mg/0.5mg buprenorphine/naloxone as needed
Dispense 8 x 2mg/0.5mg tabs as carries in vial, no witness
For induction in prescriber's office

**NO REFILLS PERMITTED**
**VOID AFTER 5 DAYS** UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898 **PRESCRIBER ID**

0000000006 **FOLIO**

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SAMPLE

## Buprenorphine/naloxone

# Example prescription of a continuation with take-home dosing

Potential scenarios as per RN/RPN scope of practice:
Continuations for patients on a stable daily dose

28-day prescription for 24mg/6mg buprenorphine/naloxone per day with all doses dispensed as take-home doses, no witnessed doses:

----------BC CONTROLLED PRESCRIPTION FORM----------

| | | | |
|---|---|---|---|
| **PERSONAL HEALTH NO.** 1234 567 890 | | | **PRESCRIBING DATE** 30 DAY / 11 MONTH / 21 YEAR |
| **PATIENT NAME** | FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name |
| **PATIENT ADDRESS** | STREET: 123 Main Street | | |
| | CITY: Victoria | PROVINCE: BC | **DATE OF BIRTH** 03 DAY / 09 MONTH / 88 YEAR |

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

Buprenorphine/naloxone 8mg/2mg

**QUANTITY (IN UNITS)**

| NUMERIC | ALPHA |
|---|---|
| 672mg | Six hundred and seventy-two milligrams |

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 01 DAY / 12 MONTH / 21 YEAR — **END DATE:** 28 DAY / 12 MONTH / 21 YEAR

| **TOTAL DAILY DOSE** NUMERIC | ALPHA | **NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION** NUMERIC | ALPHA |
|---|---|---|---|
| 24 | Twenty-four mg/day | Nil | Nil |

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Buprenorphine/naloxone 24mg/6mg sublingual once daily
Dispense all doses as carries, November 30, 2021
no witness

**NO REFILLS PERMITTED**
**VOID AFTER 5 DAYS**
**UNLESS PRESCRIPTION IS FOR OAT**

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
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Victoria BC V8Z 4H4
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Methadone

# Example prescription of a continuation, daily witnessed ingestion

Potential scenarios as per RN/RPN scope of practice:
Continuations for patients on a stable daily dose

28-day prescription for 80mg methadone per day with all doses daily witnessed ingestion:

----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.: 1234 567 890

PRESCRIBING DATE: 15 (DAY) 07 (MONTH) 21 (YEAR)

PATIENT NAME: FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

PATIENT ADDRESS: STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

DATE OF BIRTH: 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH: Methadone 10mg/mL | ONLY ONE DRUG PER FORM | VOID IF ALTERED

QUANTITY (IN UNITS): 2,240mg (NUMERIC) | Two thousand two hundred and forty milligrams (ALPHA)

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: 15 (DAY) 07 (MONTH) 21 (YEAR) | END DATE: 11 (DAY) 08 (MONTH) 21 (YEAR)

TOTAL DAILY DOSE: 80 (NUMERIC) Eighty (ALPHA) mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION: 7 (NUMERIC) Seven (ALPHA)

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS:
Methadone 80mg once daily
Daily witnessed ingestion

NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

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SAMPLE

Methadone

# Example prescription of a continuation with take-home dosing

Potential scenarios as per RN/RPN scope of practice:
Continuations for patients on a stable dose

28-day prescription for 100mg methadone per day with daily witnessed ingestion during the week and take-home doses on weekends:

----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.: 1234 567 890

PRESCRIBING DATE: 12 (DAY) 08 (MONTH) 21 (YEAR)

PATIENT NAME: FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

PATIENT ADDRESS: STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

DATE OF BIRTH: 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH: Methadone 10mg/mL

ONLY ONE DRUG PER FORM

VOID IF ALTERED

QUANTITY (IN UNITS): 2,800mg (NUMERIC) | Two thousand eight hundred milligrams (ALPHA)

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: 12 (DAY) 08 (MONTH) 21 (YEAR) | END DATE: 08 (DAY) 09 (MONTH) 21 (YEAR)

TOTAL DAILY DOSE: 100 (NUMERIC) | One hundred (ALPHA) mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION: 5 (NUMERIC) | Five (ALPHA)

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Methadone 100mg once daily
Daily witnessed ingestion Monday–Friday
Carry doses Saturday and Sunday, dispensed on Friday

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
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Methadone

# Example prescription of dose decrease

Potential scenarios as per RN/RPN scope of practice:
Following 3–4 consecutive days of missed methadone doses

5-day prescription where methadone has been decreased to 60mg per day:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 25 (DAY) 11 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

Methadone 10mg/mL

**QUANTITY (IN UNITS)**

300mg (NUMERIC) | Three hundred milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 25 (DAY) 11 (MONTH) 21 (YEAR) **END DATE:** 29 (DAY) 11 (MONTH) 21 (YEAR)

**TOTAL DAILY DOSE**

60 (NUMERIC) | Sixty (ALPHA) mg/day

**NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION**

7 (NUMERIC) | Seven (ALPHA)

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Methadone 60mg once daily
Dose decrease from 120mg/day to 60mg/day due to missed doses
Daily witnessed ingestion

**NO REFILLS PERMITTED**

**VOID AFTER 5 DAYS**
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
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Tel: 250-999-9911
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SAMPLE

Methadone

# Example prescription of a dose titration

Potential scenarios as per RN/RPN scope of practice:
Dose titrations if the patient has not stabilized on their daily dose, following missed doses and the dose needs to be re-titrated, or during restarts

1-day prescription where a methadone dose has been increased to 40mg per day:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 08 (DAY) 07 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH: Methadone 10mg/mL

ONLY ONE DRUG PER FORM

VOID IF ALTERED

**QUANTITY (IN UNITS)**
200mg (NUMERIC) | Two hundred milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

START DATE: 08 (DAY) 07 (MONTH) 21 (YEAR) | END DATE: 12 (DAY) 07 (MONTH) 21 (YEAR)

| TOTAL DAILY DOSE | | | NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION | |
|---|---|---|---|---|
| 40 (NUMERIC) | Forty (ALPHA) | mg/day | 7 (NUMERIC) | Seven (ALPHA) |

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Methadone 40mg once daily
Dose increase from 30mg/day to 40mg/day
Daily witnessed ingestion

**NO REFILLS PERMITTED**
**VOID AFTER 5 DAYS** UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898 **PRESCRIBER ID**

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Methadone

# Example prescription of a restart

Potential scenarios as per RN/RPN scope of practice:
Between 5–30 consecutive days of missed methadone doses

5-day prescription for 30mg methadone per day:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 01 (DAY) 07 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

Methadone 10mg/mL

**QUANTITY (IN UNITS)**

150mg (NUMERIC) — One hundred and fifty milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 01 (DAY) 07 (MONTH) 21 (YEAR) **END DATE:** 05 (DAY) 07 (MONTH) 21 (YEAR)

| TOTAL DAILY DOSE | | | NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION | |
|---|---|---|---|---|
| 30 (NUMERIC) | Thirty (ALPHA) | mg/day | 7 (NUMERIC) | Seven (ALPHA) |

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Methadone 30mg once daily, by mouth
Daily witnessed ingestion
Restart OAT

**NO REFILLS PERMITTED**

**VOID AFTER 5 DAYS**
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

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SAMPLE

Slow-release oral morphine

# Example prescription of a continuation, daily witnessed ingestion

Potential scenarios as per RN/RPN scope of practice:
Continuations for patients on a stable daily dose

28-day prescription for 400mg SROM, daily witnessed ingestion:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 13 (DAY) 07 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — VOID IF ALTERED

Slow-release oral morphine 400mg

**QUANTITY (IN UNITS)**

NUMERIC: 11,200mg | ALPHA: Eleven thousand two hundred milligrams

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 13 (DAY) 07 (MONTH) 21 (YEAR) **END DATE:** 09 (DAY) 08 (MONTH) 21 (YEAR)

| TOTAL DAILY DOSE | | | NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION | |
|---|---|---|---|---|
| NUMERIC | ALPHA | mg/day | NUMERIC | ALPHA |
| 400 | Four hundred | | 7 | Seven |

☑ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Slow-release oral morphine 400mg once daily, by mouth
Open capsule and sprinkle pellets
Daily witnessed ingestion

**NO REFILLS PERMITTED**

**VOID AFTER 5 DAYS**
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898 **PRESCRIBER ID**

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**PHARMACY USE ONLY**

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SAMPLE

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Slow-release oral morphine

# Example prescription of a dose decrease

Potential scenarios as per RN/RPN scope of practice:
Following 2–4 consecutive days of missed doses

1-day prescription where SROM has been decreased to 480mg per day:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 25 (DAY) 11 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

Slow-release oral morphine 480mg

**QUANTITY (IN UNITS)**

480mg (NUMERIC) | Four hundred and eighty milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 25 (DAY) 11 (MONTH) 21 (YEAR) **END DATE:** 25 (DAY) 11 (MONTH) 21 (YEAR)

| TOTAL DAILY DOSE | | NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION | |
|---|---|---|---|
| 480 (NUMERIC) | Four hundred and eighty mg/day (ALPHA) | 7 (NUMERIC) | Seven (ALPHA) |

☑ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Slow-release oral morphine 480mg once daily, by mouth
Open capsule and sprinkle pellets
Daily witnessed ingestion
Dose decrease from 800mg to 480mg due to missed doses

**NO REFILLS PERMITTED**

**VOID AFTER 5 DAYS** UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

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## Slow-release oral morphine

# Example prescription of a dose titration

Potential scenarios as per RN/RPN scope of practice:
Dose titrations if the patient has not stabilized on their daily dose, following missed doses and the dose needs to be re-titrated, or during restarts

1-day prescription where SROM has been increased to 580mg per day:

----------BC CONTROLLED PRESCRIPTION FORM----------

**PERSONAL HEALTH NO.** 1234 567 890

**PRESCRIBING DATE** 25 (DAY) 11 (MONTH) 21 (YEAR)

**PATIENT NAME** FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

**PATIENT ADDRESS** STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

**DATE OF BIRTH** 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH — ONLY ONE DRUG PER FORM — **VOID IF ALTERED**

Slow-release oral morphine 480mg

**QUANTITY (IN UNITS)**

480mg (NUMERIC) | Four hundred and eighty milligrams (ALPHA)

**THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)**

**START DATE:** 25 (DAY) 11 (MONTH) 21 (YEAR) **END DATE:** 25 (DAY) 11 (MONTH) 21 (YEAR)

| TOTAL DAILY DOSE | | NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION | |
|---|---|---|---|
| 480 (NUMERIC) | Four hundred and eighty mg/day (ALPHA) | 7 (NUMERIC) | Seven (ALPHA) |

☑ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Slow-release oral morphine 480mg once daily, by mouth
Open capsule and sprinkle pellets
Daily witnessed ingestion
Dose decrease from 800mg to 480mg due to missed doses

**NO REFILLS PERMITTED**

**VOID AFTER 5 DAYS**
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
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SAMPLE

Slow-release oral morphine

# Example prescription of a restart

Potential scenarios as per RN/RPN scope of practice:
Following 5–30 consecutive days of missed doses

1-day prescription for 200mg SROM per day:

----------BC CONTROLLED PRESCRIPTION FORM----------

PERSONAL HEALTH NO.: 1234 567 890

PRESCRIBING DATE: 06 (DAY) 12 (MONTH) 21 (YEAR)

PATIENT NAME: FIRST (GIVEN): Generic | MIDDLE / INITIAL: A | LAST (SURNAME): Name

PATIENT ADDRESS: STREET: 123 Main Street | CITY: Victoria | PROVINCE: BC

DATE OF BIRTH: 03 (DAY) 09 (MONTH) 88 (YEAR)

Rx: DRUG NAME AND STRENGTH: Slow-release oral morphine 200mg

ONLY ONE DRUG PER FORM

VOID IF ALTERED

QUANTITY (IN UNITS): 200mg (NUMERIC) | Two hundred milligrams (ALPHA)

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: 06 (DAY) 12 (MONTH) 21 (YEAR) END DATE: 06 (DAY) 12 (MONTH) 21 (YEAR)

TOTAL DAILY DOSE: 200 (NUMERIC) Two hundred (ALPHA) mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION: 7 (NUMERIC) Seven (ALPHA)

☑ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

Slow-release oral morphine 200mg once daily, by mouth
Open capsule and sprinkle pellets
Daily witnessed ingestion
Restart OAT

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION
Generic Prescriber
123 Health Street
Victoria BC V8Z 4H4
Tel: 250-999-9911
Fax: 250-999-9119

91-09898
PRESCRIBER ID

0000000001
FOLIO

PHARMACY USE ONLY

RECEIVED BY: PATIENT OR AGENT SIGNATURE

SIGNATURE OF DISPENSING PHARMACIST

SAMPLE

PHARMACY COPY - PRESS HARD YOU ARE MAKING 2 COPIES
PRINTED IN BRITISH COLUMBIA