Alcohol Use Disorder in Primary Care Handout

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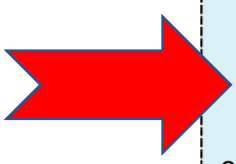
1. **Screening and diagnosis of AUD in primary care**
2. **Approach to outpatient alcohol withdrawal and when to consider referral**
3. **Discussion of first- and second-line pharmacotherapy**

1) Screening and Diagnosis of Alcohol Use Disorder in Primary Care

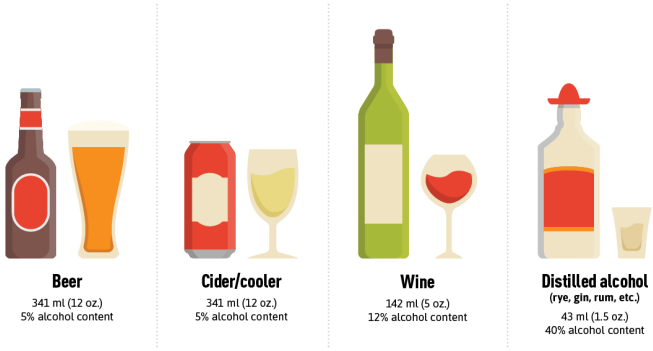
- Canada's Low Risk Drinking Guidelines (2022)
    - Previously, Women < 10 SD per week (0-2/d), Men < 15 drinks per week (0-3/d)



Canada's Guidance on Alcohol and Health, Seven Key Takeaway Messages

1. All levels of alcohol consumption are associated with some risk, so drinking less is better for everyone.
2. Among healthy individuals, there is a continuum of risk for alcohol-related harms whereby the risk is:
    - Negligible to low for individuals who consume two standard drinks or less per week;
    - Moderate for those who consume between three and six standard drinks per week; and
    - Increasingly high for those who consume more than six standard drinks per week.
3. On any occasion, any level of consumption has risks, and with more than two standard drinks, most individuals will have an increased risk of injuries or other problems
4. Disproportionately more injuries, violence and deaths result from men's drinking.
5. Above low levels of alcohol consumption, the health risks increase more steeply for women than for men.
6. It is safest not to drink alcohol while pregnant and during the pre-conception period.
7. For women who are breastfeeding, it is safest not to use alcohol.

- <u>Universal screening annually</u>
    - Many tools AUDIT, CAGE, SASQ
- Standard drink = 17.05 mL or 13.45 g of pure alcohol
- Alcohol Use Disorder DSM 5 diagnosis
    - Mild 2-3, Moderate 4-5, Severe 6+
    - See resources



2) Alcohol Withdrawal Management in Primary Care

Box 12 Prediction of Alcohol Withdrawal Severity Scale (PAWSS)[195]

MD Calc (App)

PART A: THRESHOLD CRITERIA — Yes or No, no point	
Have you consumed any amount of alcohol (i.e., been drinking) **within the last 30 days**? **OR** Did the patient have a positive (+) blood alcohol level (BAL) on admission?	
If the answer to either is YES, proceed to next questions.	
PART B: BASED ON PATIENT INTERVIEW — 1 point each	
1	Have you been recently **intoxicated/drunk**, within the last 30 days?
2	Have you **ever** undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance)
3	Have you **ever** experienced any previous episodes of alcohol withdrawal, regardless of severity?
4	Have you **ever** experienced blackouts?
5	Have you **ever** experienced alcohol withdrawal seizures?
6	Have you **ever** experienced delirium tremens or DTs?
7	Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, **during the last 90 days**?
8	Have you combined alcohol with any other substance of abuse, **during the last 90 days**?
PART C: BASED ON CLINICAL EVIDENCE — 1 point each	
9	Was the patient's blood alcohol level (BAL) greater than 200mg/dL? (SI units 43.5 mmol/L)* **OR** *Have you consumed any alcohol in the past 24 hours?
10	Is there any evidence of increased autonomic activity? e.g., heart rate >120 bpm, tremor, agitation, sweating, nausea

*Due to the common absence of a BAL the committee has added this modification. Please see next page.

Interpretation

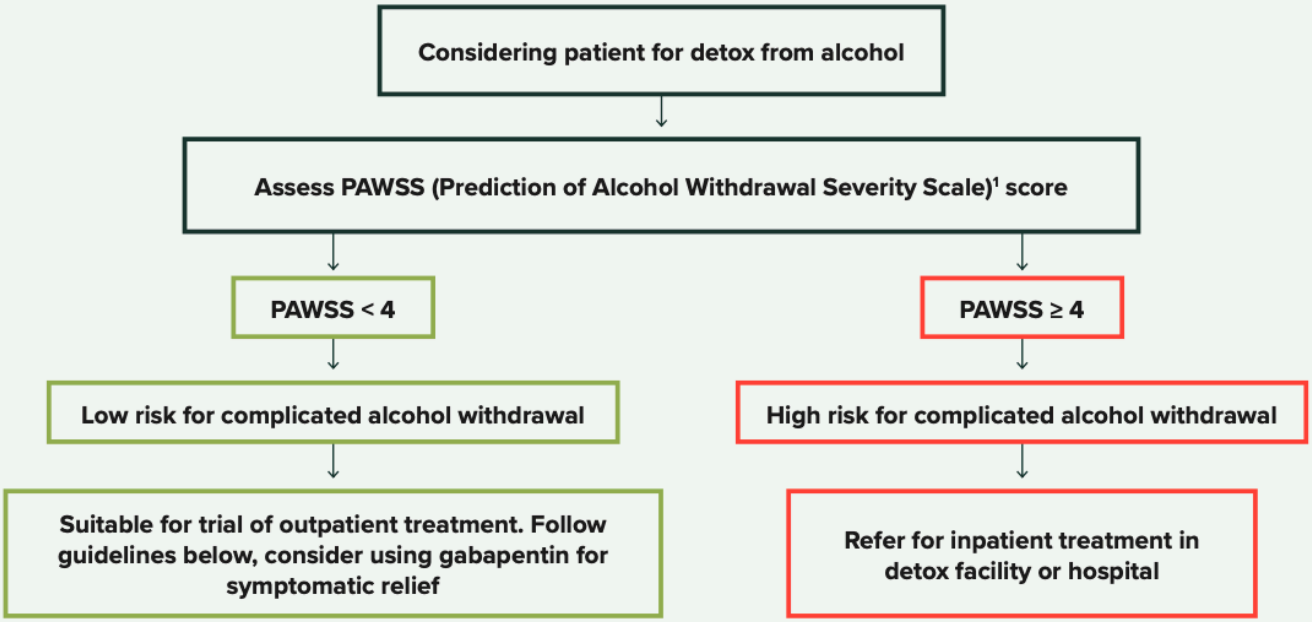
Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndrome (AWS).

A score of ≥4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or inpatient treatment are indicated.

QUICK GUIDE TO OUTPATIENT TREATMENT OF ALCOHOL USE DISORDER

Sulara Guruge MD, Peter Kelly MD, and Armon Molavi MD

Alcohol Withdrawal as an Outpatient - Page 2



Tips for managing outpatient alcohol withdrawal

- Patient should have a reliable caregiver
- Start early in the week and assess the patient daily x 3-4 days for vitals, withdrawal symptoms, hydration, orientation, sleep, and general condition
- Consider prescribing **gabapentin 300 mg PO TID** for withdrawal symptoms, can add 300 mg PRN per dose to a maximum of 1800 mg and consider daily dispensing, caution in renal failure
- Prescribe **thiamine 100 mg PO TID x 1 week**, then daily x 2 months, as well as a daily multivitamin
- Encourage patient engagement with psychosocial supports

Contraindications to outpatient management include:

- any history of withdrawal seizure or delirium
- unstable medical or psychiatric conditions
- concurrent sedative use disorders
- pregnancy
- multiple failed attempts
- lack of safe setting and caregiver

Note on Benzodiazepines:

- Benzos are gold standard to manage alcohol withdrawal
- However, they pose significant risk in an unsupervised setting including abuse, over sedation, respiratory depression, falls, delirium
- 80% of alcohol withdrawal syndrome does not require aggressive medical intervention, such as with benzodiazepines, hence why we screen with PAWSS
- Anticonvulsants, such as gabapentin, have been shown to be safer and are effective for mild to moderate withdrawal symptoms

References and Resources:

- Adapted from BC Guidelines on Problem Drinking and BC Centre on Substance Use with input from addiction medicine specialists
- Alcohol Screening, Brief Intervention and Referral (SBIR): Helping Patients Reduce Alcohol-related Risks and Harms is a resource for Canadian family physicians
- For consultative support, contact the RACE line for Addiction Medicine: 1-877-696-2131
- Go to https://www.surveymonkey.com/r/D2YKM97 for a quiz to test your knowledge and/or to provide any feedback on the handout

[1]Prediction of Alcohol Withdrawal Severity Scale is an evidence based screening tool to assess the likelihood that a patient will experience complicated alcohol withdrawal: https://www.mdcalc.com/prediction-alcohol-withdrawal-severity-scale
Digital copy can be accessed at: https://tinyurl.com/audhandout

- Medical treatment for outpatient withdrawal
    - Gabapentin (off label)
        - *NOT EFFECTIVE FOR SEVERE WITHDRAWAL*
        - 300 mg PO TID + 300 mg PRN + 600-1200 mg HS
        - Titrate to 600 mg TID + 600-1200 mg HS
        - Max 3600 mg/day
        - Taper when acute symptoms resolve, reducing by 600 mg/day
    - Benzodiazepines
        - Diazepam or Lorazepam
            - Consider fixed schedule - limit risks, short course (5-7 days)
        - Day 1 Diazepam 10 mg QID
        - Day 2 Diazepam 10 mg TID
        - Day 3 Diazepam 10 mg BID
        - Day 4 Diazepam 10 mg qHS
    - Thiamine 100 mg PO daily – maybe forever
- Follow Up
    - See on slide, daily is ideal, CIWA scoring, vitals, overall check-in,
    - Resolution around day 5-7
- When to refer:
    - High risk for complicated withdrawal
        - Elevated PAWSS, clinical picture, failing outpatient therapy
        - 20% will require inpatient withdrawal management

Patients at high risk of severe complications of withdrawal (i.e., PAWSS≥4) should be referred to an inpatient facility (i.e., withdrawal management facility or hospital) where they can receive a benzodiazepine treatment regimen under close observation, and emergency care can be administered immediately if needed.

Quality of Evidence: HIGH	Strength of Recommendation: STRONG

Remarks

- Conditions that could indicate inpatient withdrawal management regardless of PAWSS score include:
    - Multiple unsuccessful attempts at outpatient withdrawal management
    - Failure to respond to medications after 24-48 hours
    - Unstable medical conditions
    - Unstable psychiatric disorders
    - Chronic, complex pain disorders
    - Concurrent use of other CNS depressants (e.g., prescribed or nonmedical use of Z-drugs, benzodiazepines, barbiturates, opioids)
    - Severe liver compromise (e.g., jaundice, ascites, decompensated cirrhosis)
    - Pregnancy
    - Lack of a safe, stable, and substance-free setting and/or caregiver to dispense medication
- If a patient has a PAWSS≥4 but inpatient treatment is not feasible due to patient preference or scarcity of beds, clinicians should arrange for community-based monitoring and support during treatment (home withdrawal programs, intensive outpatient programs (DayTox), connection with community pharmacist, involving family members or caregivers) and monitor patient closely (daily phone calls, frequent clinical visits).

3) Discussion of First- and Second-Line Pharmacotherapy for AUD

- Fill out collaborative prescribing agreement!
- Do NOT need to wait until out of withdrawal

First-line AUD Pharmacotherapies

	Naltrexone[309]	Acamprosate[310]
Contraindications	1. History of sensitivity to naltrexone 2. Current opioid use or opioid use disorder (analgesia, opioid agonist treatment, or non-medical use) 3. Acute opioid withdrawal 4. Acute hepatitis or liver failure	1. History of hypersensitivity to acamprosate 2. Severe renal impairment (creatinine clearance ≤ 30 mL/min) 3. Breastfeeding
Cautions	1. Renal impairment 2. Hepatic impairment 3. Concomitant use of other potentially hepatotoxic drugs 4. Pregnancy and breastfeeding* 5. Pediatric patients (<18 years)*	1. Moderate renal impairment (creatinine clearance of 30-50mL/min) 2. Pregnancy* 3. Pediatric and geriatric (>65 years) patients*
Side Effects	Nausea, headache, and dizziness. These are generally mild and temporary. Can be avoided if naltrexone is started at a lower dose and/or if the patient is abstinent from alcohol.	Diarrhea is the most commonly reported side effect, vomiting and abdominal pain are reported less frequently. Side effects are usually transient and resolve quickly.
Coverage	Collaborative Prescribing Agreement is required; eligible for full coverage under Fair PharmaCare, and PharmaCare Plans C, G, and W.	Collaborative Prescribing Agreement is required; eligible for full coverage under Fair PharmaCare, and PharmaCare Plans C, G, and W.
Concurrent Alcohol Use	Safe to start while patients are using alcohol, but may be more effective and side effects minimized if started following completion of withdrawal management.[178,179]	Safe to start while patients are using alcohol, but may be more effective if started following completion of withdrawal management.[177,178]
Safety and Other Considerations	• Liver function tests (LFT) should be assessed at treatment initiation, and again at 1, 3, and 6 months. If LFTs are elevated at baseline, more frequent monitoring is indicated. • Patients should be advised of the risk of hepatic injury and to stop use of medication if they experience symptoms of acute hepatitis (fatigue, anorexia, nausea, and vomiting).	• No dose adjustment is required for patients with mild renal impairment (creatinine clearance 50-80 mL/min). • Dose reduction is required for patients with moderate renal impairment (creatinine clearance 30-50 mL/min).[31] • No known hepatic toxicities.
Dosing[284]	• Start at 12.5 mg once daily. • Titrate up as tolerated to 50 mg once daily over 2 weeks.	Two 333 mg tablets three times per day.

Gabapentin[258]	
Contraindications	Hypersensitivity to gabapentin
Cautions	Renal impairment
Side Effects	Side effects include ataxia, slurred speech, and drowsiness. Most are mild to moderate in severity, and occur early in therapy.
Coverage	Gabapentin is eligible for full coverage under Fair PharmaCare, and PharmaCare Plans C and W.
Concurrent Alcohol Use[258,261]	If taken at a higher than therapeutic dose and concurrently with alcohol or opioids, the risk of respiratory depression, profound sedation, syncope, and death is increased. Patients who use alcohol or other CNS depressants should be observed carefully for signs and symptoms of CNS depression, and the dose of gabapentin may need to be adjusted accordingly. **Note:** Studies suggest concomitant use of alcohol and gabapentin at therapeutic doses does not increase sedation or motor impairment.
Safety and Other Considerations	• Patients with compromised respiratory function, respiratory or neurological disease, renal impairment and the elderly are at higher risk of experiencing severe adverse effects on the CNS including sedation, somnolence, loss of consciousness as well as serious cases of respiratory depression. • Gabapentin is eliminated primarily by renal excretion; dosage adjustment may be required in elderly patients and patients with renal impairment. • Prescribers should review gabapentin's drug-drug interactions when considering this medication as treatment for AUD. • Care should be taken when prescribing to the elderly, those with renal impairment, or those with cognitive impairment. In these populations, close follow-up must be ensured. Do not prescribe to actively delirious patients.
Sample Dosing Protocol[261,328]	• Start gabapentin at a dose of 100 mg to 300 mg TID. • If the patient continues to experience anxiety or cravings, TID doses can be increased up to a suggested maximum daily dose of 1800 mg. • If patient continues to experience insomnia, a higher HS dose may be warranted. **Note:** This protocol applies to immediate-release (IR) tablets.

Questions?

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BC Centre on Substance Use (2019). *Provincial Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder. A*ccessed from https://www.bccsu.ca/wp-content/uploads/2021/01/AUD-Guideline.pdf

Canadian Centre on Substance Use and Addiction (2022). *Update of Canada's Low-Risk Alcohol Drinking Guidelines: Final report for public consultation*. Accessed from https://ccsa.ca/sites/default/files/2022-08/CCSA-LRDG-Update-of-Canada%27s-LRDG-Final-report-for-public-consultation-en.pdf

Molavi, Guruge, and Kelly (2020). *Outpatient treatment of alcohol use disorder.* BC medical Journal 62(8) accessed from https://bcmj.org/articles/outpatient-treatment-alcohol-use-disorder

Table 10 DSM-5 Diagnostic Criteria for Alcohol Use Disorder[2]

	A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period, indicates presence of an AUD.[2]	Sample Clinical Interview Questions[573] In the past year (12 months), have you...
1	Alcohol is often taken in larger amounts or over a longer period than was intended	Had times when you ended up drinking more, or longer, than you intended?
2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use	More than once wanted to cut down or stop drinking, or tried to, but couldn't?
3	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects	Spent a lot of time drinking? Or being sick, or getting over other aftereffects of drinking?
4	Craving, or a strong desire or urge to use alcohol	Wanted a drink so badly you found it hard to think of anything else?
5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home	Found that drinking, or being sick from drinking, often interfered with taking care of your home or family? Have you missed work or class due to alcohol use?
6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol	Continued to drink even though it was causing trouble with your family or friends?
7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use	Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
8	Recurrent alcohol use in situations in which it is physically hazardous	More than once, gotten into situations while or after drinking that increased your chances of being harmed, such as drinking and driving, or having unplanned or unsafe sex?
9	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol	Continued to drink even though it was making you feel depressed or anxious, or adding to another health problem? Or, continued drinking after having a memory blackout?
10	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount of alcohol	Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
11	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms	Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?

Severity: MILD: presence of 2-3 symptoms, MODERATE: presence of 4-5 symptoms, SEVERE: presence of 6 or more symptoms.

Modifiers for the diagnosis include:

- **Early remission:** After full criteria for AUD were previously met, none of the criteria for AUD have been met (with the exception of craving) for at least 3 months but less than 12 months.
- **Sustained remission:** After full criteria for AUD were previously met, none of the criteria for AUD have been met (with the exception of craving) during a period of 12 months or longer.
- **Controlled environment:** If the individual is in an environment where access to alcohol is restricted.

Pharmacotherapy Options for Alcohol Use Disorder

	First Line Pharmacotherapy		*Second Line Pharmacotherapy*	
	Naltrexone	**Acamprosate**	**Topiramate**	**Gabapentin**
Concurrent Alcohol Use	No well-described safety risk Tx after WDM may be more effective	No well-described safety risk Tx after WDM may be more effective	No well-described safety risk	No well-described safety risk at therapeutic dose Abstinence recommended after tx Abstinence for ≥3 days may improve outcomes
Contra-indications	1. Naltrexone hypersensitivity 2. Any current opioid use (Rx or nonmedical) 3. Acute opioid withdrawal 4. Acute hepatitis or liver failure	1. Acamprosate hypersensitivity 2. Severe renal impairment 3. Breastfeeding	1. Topiramate hypersensitivity 2. Pregnant or planning pregnancy 3. Narrow angle glaucoma 4. Nephrolithiasis	Gabapentin hypersensitivity
Cautions	1. Renal impairment 2. Severe hepatic impairment 3. Concomitant use of other potentially hepatotoxic drugs 4. Pregnancy and breastfeeding* 5. Adolescent patients (<18 years)*	1. Moderate renal impairment 2. Adolescent and geriatric (>65 years) patients* 3. Pregnancy*	1. Concomitant use of valproic acid 2. Conditions/therapies that predispose to acidosis	1. Renal impairment 2. Pregnancy and breastfeeding* 3. Adolescent and geriatric (>65 years) patients* 4. Concomitant use of opioids and other CNS depressants 5. Compromised respiratory function 6. Neurological disease or cognitive impairment
Side Effects	Nausea, headache, and dizziness Starting at low dose and/or abstinence can reduce side effects	Diarrhea, vomiting, and abdominal pain	Psychomotor slowing, difficulty concentrating, speech/language problems, somnolence, fatigue, and mood disturbance Starting at low dose and titrating up can reduce side effects	Ataxia, slurred speech, and drowsiness
Coverage and Cost**	Full coverage under Fair PharmaCare, and PharmaCare Plans C, G, and W Requires the Collaborative Prescribing Agreement		Full coverage under Fair PharmaCare, and PharmaCare Plans C and W	
	$105 per month	$165 per month	$75 per month	$30 per month
Safety and Other Considerations	Liver function tests (LFT) at initial tx, and 1, 3, and 6 mo. More frequent monitoring if LFTs are elevated Due to risk of hepatic injury, advise patients on signs of acute hepatitis and to stop tx if symptoms appear	No safety risk w/ mild renal impairment Moderate impairment requires dose reduction No hepatic toxicity	Due to risk of fetal harm, advise women to use effective contraception No safety risk w/ liver disease Monitor for signs of hyperammonemia and metabolic acidosis	No safety risk w/ liver disease Requires conservative dosing in patients with renal impairment
Dosing	**Start:** 12.5mg BID for 3 days **Titrate:** to 50mg OD over 2 wks as tolerated	2 x 333mg tablets TID	**Titrate:** to 2 x 50mg tablets BID over several wks as tolerated	**Start:** at 100-300mg TID, **Titrate:** PRN to 1800mg max daily

*Safety and efficacy has not been well established in these patient populations. Careful assessment of benefit and risks, fully informed patient consent, and more frequent monitoring is advised.
**Estimated cost if patient is not eligible for coverage
Abbreviations: WDM – withdrawal management, PRN – as needed/when necessary, TID – three times per day, BID – two times per day, OD – once daily

Pharmacotherapy Options for Outpatient Management of Alcohol Withdrawal

	Benzodiazepines	Carbamazepine	Gabapentin	Clonidine
Concurrent Alcohol Use	Potentiates effects of alcohol; can lead to serious safety risks, incl. over sedation, falls, delirium, respiratory depression (e.g., non-fatal or fatal overdose), and prolonged hospitalization	No well-described safety risk	Abstinence recommended after tx due to risk of additive CNS-depressive effects *Note:* Studies suggest at therapeutic doses gabapentin is **not** likely to increase sedation or motor impairment	Risk of additive effect on lowering BP
Contra-indications	1. Severe respiratory insufficiency 2. Hepatic disease 3. Sleep apnea 4. Myasthenia gravis 5. Narrow angle glaucoma	1. Hepatic disease 2. Bone marrow depression 3. Serious blood disorder 4. Atrioventricular heart block	Hypersensitivity to gabapentin	1. Sinus node function impairment 2. Severe bradyarrhythmia 3. Galactose intolerance
Cautions	1. Lactose intolerance 2. Renal impairment 3. Breastfeeding	Associated with rare blood dyscrasias and Stevens Johnson Syndrome with long-term use *Asian ethnicity increases risk of carbamazepine toxicity	Renal impairment	Hypotension in sensitive patients
Side Effects	Drowsiness, dizziness Less common: changes in skin colour, nausea, headache, blurred vision, tremors, hypotension, GI disturbances, memory loss	Dizziness, pruritus, ataxia, headache, drowsiness and nausea (all usually minor and temporary)	Higher doses may cause ataxia, slurred speech and/or drowsiness Profile is better than other anticonvulsants.	Hypotension, dry mouth, dizziness, fatigue, headache, nausea, vomiting, constipation, malaise, sleep disorder, sedation and erectile dysfunction
Other Considerations	Potential for non-medical use, diversion, and dependence Potential for drug-drug interactions leading to excess sedation, impaired psychomotor and cognitive functioning. Due to safety concerns, exercise caution with outpatient use Lorazepam is preferred for those with severe respiratory or liver disease and in elderly (consider lower dosing)	No risk of non-medical use, diversion, or dependence Some side effects resemble w/drawal symptoms; confirm source of symptoms before dose adjustments Baseline and periodic evaluations of hepatic function must be performed in elderly patients and patients w/ history of liver disease	Potential for non-medical use, diversion, and dependence Toxicity profile parallels that of alcohol. Easy to transition from WDM to long-term relapse prevention.	Only use for mild-moderate w/drawal symptoms when low risk of severe complications Safe as adjunct to benzodiazepines or other anticonvulsants Provide education on the signs and symptoms of hypotension
Dosing	Diazepam (Valium) Day 1: 10mg QID Day 2: 10mg TID Day 3: 10mg BID Day 4: 10mg HS Lorazepam (Ativan) Day 1-2: 2mg every 4h Day 3-4: 1mg every 4h	For immediate-release tablets Day 1: Start with 200mg QID Day 2: Taper down to 200mg TID Day 3: 200mg BID Day 4-5: 200mg HS	For immediate-release tablets **Start** 300mg TID + 300mg PRN +600-1200mg HS **Titration** Quickly to 600mg TID + 600-1200mg HS as tolerated Do not exceed 3600mg daily **Taper when acute symptoms resolve** To 600mg TID + 600-900mg HS To zero over next 3-5 days, decreasing dose by 600mg daily	Typically an adjunct tx Start: 0.1-0.2mg BID (last dose HS) Titrate: Can add 0.2mg daily if needed Final dose: Range 0.1-0.6mg BID

All medications are eligible for full coverage under Fair PharmaCare, and PharmaCare Plans C and W.
Abbreviations: BP – blood pressure, PRN – as needed/when necessary, QID – four times per day, TID – three times per day, BID – two times per day, OD – once daily, HS – at bedtime
*Due to higher prevalence of the HLA-B*1502 allele. Genetic testing must be performed to exclude those at high-risk

Collaborative Prescribing Agreement

NALTREXONE and ACAMPROSATE for the Treatment of Alcohol Dependence

This Collaborative Prescribing Agreement (the "Agreement") is entered into by the Pharmaceutical Services Division, BC Ministry of Health, and the undersigned prescriber.

To obtain PharmaCare coverage on my patients' behalf for naltrexone (ReVia®) or acamprosate (Campral®), I, _____, [*Name of physician - please print*] agree to prescribe according to the following Limited Coverage criteria:

Naltrexone	For the treatment of alcohol use disorder **AND** in combination with behavioural intervention therapy (e.g., psychosocial counselling) as necessary. *Approval period: 1 year*
Acamprosate	For the maintenance of abstinence in patients who have been abstinent from alcohol for at least four days **OR** for the treatment of alcohol use disorder for patients who have contraindications to naltrexone (i.e., concurrent opioid use, acute hepatitis, or liver failure) **AND** in combination with behavioural intervention therapy (e.g., psychosocial counselling) as necessary. *Approval period: 1 year*

Terms of the Agreement:

- The Pharmaceutical Services Division reserves the right to implement Collaborative Prescribing Agreements for PharmaCare coverage; require renewals of such Agreements; and, as necessary, conduct quality assurance checks of such processes. For quality assurance purposes, a physician with a valid exemption agrees to receive feedback on his/ her prescribing of naltrexone or acamprosate, such as de-personalized, aggregate prescribing data.
- Patients whose prescriptions for naltrexone or acamprosate are written by a prescriber who has entered into an Agreement will receive automatic coverage for their subsequent claim.
- PharmaCare coverage is **not** retroactive. A current valid Agreement must be in place **before** a patient fills a prescription. PharmaCare coverage for naltrexone or acamprosate is available only with a valid Agreement.
- If a patient does **not** meet the terms of this Agreement, the prescriber must write the following instruction to pharmacists **on** the prescription "Submit as zero cost to PharmaCare," indicating that the prescription is not to be covered by PharmaCare.
- A physician's exemption under this Agreement may be discontinued if the exempted physician prescribes naltrexone or acamprosate in a manner inconsistent with the terms of this Agreement.

Name of prescriber (please print)	College of Physicians & Surgeons ID Number
Prescriber signature	Medical Services Plan Billing Number
Date submitted	Fax # (to which confirmation of exemption should be sent) 250-519- 5159

FAX COMPLETED AGREEMENT TO HEALTH INSURANCE BC at 1-250-405-3599

A copy of this Agreement will be kept on file at the Ministry of Health.

Pharmaceutical Services Division Use Only:

Effective date: _____ Approval period for exemption: **Indefinite** Approved on behalf of PSD: _____ Confirmation sent: (Date) _____	**DBR Operational Information**: ID reference number for CPSBC = **91** Category and subcategory code = 9901-0144 (naltrexone), 9901-0143 (acamprosate) Assumed SA = **No**