Department of Health

GUIDELINE

Tasmanian Government

Clinical guidelines for pharmacist administration of depot buprenorphine in the treatment of opioid dependence

SDMS Id Number	Assigned through HPRM
SDMS Category	Assigned by Policy team
Effective Date	September 2022
Review Date	September 2023
Applies to	Community-based pharmacists
Key Words	Long-acting, depot, buprenorphine, BPN, pharmacist, opioid, dependence

1 Guideline Statement

This guideline should be read in conjunction with the Tasmanian Opioid Pharmacotherapy Program Policy and Clinical Practice Standards (TOPP), the *Pharmacist Administration of Depot Buprenorphine in the Treatment of Opioid Dependence Policy* and the *Interim Brief Clinical Guidelines for Administration of Depot Buprenorphine Buvidal® and Sublocade® in the Treatment of Opioid Dependence*.

The aim of the guideline is to provide guidance to community-based pharmacists in the administration of depot buprenorphine (BPN).

Evidence Based Rationale

Opioid dependence is a chronic and relapsing disorder that affects physical and mental health and social wellbeing and function. Opioid Replacement Therapy (ORT) is an evidence-based treatment for opioid dependence. To date, ORT medications have been administered orally in liquid, tablet and sublingual film formulations, on a once or interval day regimen. Risks associated with ORT medications in these formulations include diversion, non-medical use, and overdose. Due to the risks these medications require supervised dosing. The requirement for supervised daily, or interval, dosing has great impact upon the client and service providers and can be a barrier to treatment engagement and retention.

In 2018 (Buvidal®) and 2019 (Sublocade®) depot BPN was approved for use in Australia by the Therapeutic Goods Administration (TGA) for 'maintenance treatment of opioid dependence within a framework of medical, social and psychological support'. Depot BPN reduces the risk of diversion, non-medical use and overdose, provides increased freedom for clients, reduced treatment costs for clients and service providers, and greater treatment adherence and outcomes.

2 Process

Pharmacies / health services and pharmacists **must** be:

- accredited as current Opioid Pharmacotherapy Program (OPP) providers; and
- holds a Program Approval to conduct a vaccination service; and
- Authorised Pharmacist Immunisers with current Department of Health (DoH) approval

prior to seeking approval to administer depot BPN.

Pharmacists should adhere to the following guidelines to ensure clients receive safe delivery of depot BPN within a community-based pharmacy / health service setting.

The following process is summarised as a checklist in Appendix A.

2.1 Preparation

2.1.1 Premises, Equipment and Records

The community-based pharmacy / health service and the individual pharmacist administering depot BPN must be accredited as a current OPP provider under the framework of the TOPP. The TOPP is currently under review, and as an interim measure the Alcohol and Drug Service (ADS) is the accrediting body.

A copy of relevant training certificate/s should be retained on the premises and made available if requested.

A dedicated, private consultation area should be available for the administration of depot BPN. The area must meet the Tasmanian Pharmacy Authority's requirements for a Vaccination Area in a Pharmacy Business Premises, which include:

- Privacy for the client in terms of sound and visibility
- A consultation area which is accessible and inclusive – consider the individual client's identity, abilities, and cultural needs
- A sharps disposal bin
- Medical waste bin
- Hand hygiene facilities
- Access to a fridge which is monitored twice daily in accordance with the Strive for 5 requirements
- Room for a client to lie down and have first aid / CPR administered
- Sufficient room for all necessary equipment and records
- Seating nearby, visible from dispensary, to observe clients after injection
- Security and privacy of any / all client records either stored there or as relevant for the day's business. Stored documents may include:
    - the client's personal information
    - clinical documentation
    - receipt of prescription
- An up-to-date anaphylaxis response kit (example – Appendix B) and anaphylaxis emergency protocol (example – Appendix C)

Additionally, premises should have:

- Adequate injection administration consumables
- A drug register in which the administration of depot BPN **must** be recorded; and
- Storage facilities that comply with:
    - the *Poisons Regulations 2018* for Schedule 8 medications; and
    - the requirements for the correct and safe storage of the relevant medication.
- Naloxone available for take-home and emergency use. Naloxone has been available for free without prescription from 1 July 2022 under the Commonwealth Take Home Naloxone Program.

2.1.2 Staffing

The pharmacist must be able to leave the dispensary for the time required to:

- assess the client pre-injection; and

- administer the injection; and
- conduct appropriate post-injection observation and record keeping.

When pharmacists are conducting pre-injection assessment and administration, they should not engage in any other activity, including dispensing.

2.2 Pre-administration

2.2.1 Transfer of Care

2.2.1.1 Transfer from Prescriber to community-based pharmacy

The most appropriate time for a client to transition a community-based pharmacy or health service for the administration of depot BPN should be decided by the prescriber in consultation with the client on an individual basis. Factors to be considered include:

- Client complexity
- Treatment stability
- Potential barriers to access / continuity of treatment

The client must be fully informed about all considerations and be included in decision making.

An agreed frequency and method of communication should be established between the prescriber and pharmacist prior to the transfer of care. The agreed communication plan may vary based on clinical need (e.g. regular communication regarding treatment progress versus communication on an as needed basis).

If there is a need for the client to revert to prescriber administration, clear communication of this plan is essential between the pharmacist, prescriber and client for safe coordination and continuity of care.

2.2.1.2 Transfer from community-based pharmacy to community-based pharmacy

There may be instances where a client needs to change pharmacies for the administration of their depot BPN. A transfer may be short or long term. The prescriber must notify the community-based pharmacy of the intention to transfer, and the current pharmacy must provide the prescriber and the new pharmacy with a transfer of care document. The transfer of care must, at a minimum, include the following information:

- Date of last depot BPN
- Dose of last depot BPN
- Site of last depot BPN administration
- Client identification sheet
- Any other critical information

If there are repeats remaining on the client's current script a transfer of Schedule 8 medication prescription must be sought from the Pharmaceutical Services Branch (PSB).

2.2.2 Pre-administration assessment and information

Prior to injection administration, the pharmacist should undertake a holistic review with the client considering factors including:

- confirmation of injection due date
- review of previous dose adequacy
- any previous adverse events
- general client health and wellbeing

Pre-injection observations should be documented, and any concerns escalated to the prescriber as appropriate.

The following circumstances require escalation to the prescriber **prior to the administration** of the injection, with the exception of clients presenting in opioid withdrawal:

- Immediate concerns with dosing, which may include:
    - signs of intoxication (with any substance)
    - opioid withdrawal
    - presentation for dosing outside of eligible date range
- Significant change in mental or physical health, which may include:
    - pregnancy
    - severe respiratory insufficiency
    - hepatic insufficiency
    - acute alcoholism or delirium tremens

A valid prescription must also be confirmed prior to injection administration.

2.3 Administration

After the pre-administration assessment is complete, the dose should be aseptically administered using subcutaneous injection technique specific for the depot BPN formulation prescribed. See Appendix D for Buvidal® technique, Appendix E for Sublocade® technique.

Depot BPN administration requires the client to expose skin and/or remove clothing. The pharmacist should ensure client privacy is considered and provide the option to either sit or lie down to receive the injection. The pharmacist should be mindful that some clients may have a history of trauma which has an impact on their engagement in treatment, and pharmacists should be responsive to the individual client's needs.

NOTE WHEN USING SUBLOCADE®: The lifespan of Sublocade® decreases when removed from refrigerator. Once outside the refrigerator Sublocade® may be stored in its original packaging at room temperature (below 25°C) for up to 28 days prior to administration. Sublocade® must be discarded if left at room temperature for longer than 28 consecutive days.

Once removed from the refrigerator, Sublocade® may be returned to the refrigerator only when:

- It has been at ambient temperature (less than 25°C) for less than 12 hours – this cycle may occur twice without the need to discard the product; OR
- It has been at ambient temperature (less than 25°C) for less than 24 hours – this cycle may occur once without the need to discard the product.

For medication safety, when removing Sublocade® from a refrigerator the date **must** be noted in the instance that the product is not used when intended.

2.4 Post administration

It is advised that pharmacists keep clinical records to ensure accuracy of communication with prescribers. Pharmacists should communicate these with the prescriber as agreed / required.

Brief clinical notes should include:

- Any issues from the previous dose, including withdrawal or sedation
- Information on the medication administered (name, dose, expiry, batch)
- Site of administration (to ensure this is rotated each administration)
- Any substance related issues, including opioid related issues
- Any changes to existing, or commencement of new, medications and / or over the counter (OTC) medications / vitamins / supplements
- Any health issues since the previous dose
- Any non-health / social issues since the previous dose

- Any social or clinical information the prescriber may require, including adverse events (adverse events must also be reported to the Therapeutic Goods Administration (TGA)).

Any adverse events must be reported to the TGA and the client's prescriber as soon as practicable.

In certain circumstances, it is appropriate for the client to remain on the pharmacy premises for a short period of time (15 minutes) post administration to allow for monitoring. (i.e., first injection, dosing stability not established or previous adverse events)

Prior to their departure from the pharmacy, confirm the date of their next dose with the client.

A suggested record keeping template is available in Appendix F.

3 Responsibilities

Responsibilities relating to the administration of depot buprenorphine by pharmacists in community-based pharmacies / health centres are outlined in the *Pharmacist Administration of Long-acting Depot Buprenorphine in the Treatment of Opioid Dependence Policy.*

4 References

1 New South Wales Ministry of Health. NSW Clinical Guidelines: Treatment of Opioid Dependence – 2018. New South Wales: New South Wales Ministry of Health, 2018. Pp132.

2 Lintzeris, N, Dunlop, A, Masters, D. Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence. New South Wales: New South Wales Ministry of Health, 2019. Pp. 56.

3 Department of Health Victoria. Policy for Maintenance Pharmacotherapy for opioid dependence (addendum) long-acting buprenorphine. Victoria: Department of Health Victoria, 2021. Pp. 15.

4 The Pharmacy Guild of Australia. Pharmacist-administered depot buprenorphine in community pharmacy: Pilot Project [Internet]. Australian Capital Territory: The Pharmacy Guild of Australia; 2022 [updated 17 June 2022; cited 19 September 2022]. Available from: Pharmacist-administered depot buprenorphine in community pharmacy: Pilot Project - Pharmacy Guild of Australia

5 Australian Immunisation Handbook [Internet]. Australian Capital Territory: Australian Government, Department of Health and Aged Care, 2021. Preparing an anaphylaxis response kit; 2021 [cited 19 September 2022]. Available from: Preparing an anaphylaxis response kit | The Australian Immunisation Handbook (health.gov.au)

6 NPS MedicineWise. Anaphylaxis: Emergency management for health professionals [Internet]. New South Wales: MedicineWise; 2018 [updated 2 April 2018, cited 19 September 2022]. Available from: Anaphylaxis: emergency management for health professionals - Australian Prescriber (nps.org.au)

5 Related Documents

- Poisons Standard June 2022
- Poisons Act 1971
- Poisons Regulations 2018
- Tasmanian Opioid Pharmacotherapy Program: Policy and Clinical Practice Standards
- Pharmacist Administration of Long-acting Depot Buprenorphine in the Treatment of Opioid Dependence Policy
- Interim Brief Clinical Guidelines for Use of Depot Buprenorphine Buvidal® and Sublocade® in the Treatment of Opioid Dependence
- Skills Assessment Record – Depot Buprenorphine

6 Acknowledgements

The Tasmanian Department of Health acknowledges the work of the following individuals and organisations in the development of this document:

- The Australian Government, Department of Health and Ageing

- The New South Wales Ministry of Health Centre for Alcohol and Other Drugs, The University of Sydney School of Pharmacy, The Pharmaceutical Society of Australian (NSW Branch) and the Pharmacy Guild of Australian (NSW Branch) – Pharmacy-administered depot buprenorphine in community pharmacy: Pilot Project
- The Victorian Department of Health
- The Pharmacy Guild of Australia (Tasmanian Branch)
- The Pharmaceutical Society of Australia (Tasmanian Branch)
- Tasmanian Department of Health agencies:
    - Alcohol and Drug Service
    - Pharmaceutical Services Branch
    - Infection Prevention and Control Unit
    - Public Health Services
- Community Pharmacists
- NPS MedicineWise
- Professor Nick Lintzeris, Professor Adrian Dunlop, and Debbie Masters

7 Attachments

1 Appendix A – Depot BPN administration checklist

2 Appendix B – Example: Preparing an Anaphylaxis Response Kit

3 Appendix C – Example: Anaphylaxis: Emergency Management Protocol

4 Appendix D – Buvidal® depot BPN abbreviated administration technique

5 Appendix E – Sublocade® depot BPN abbreviated administration technique

6 Appendix F – Record Keeping Template

Appendix A – Depot BPN administration checklist

Service Preparation

- ☐ The Pharmacist:
  - is an Authorised Pharmacist Immuniser
  - is aware of relevant policy, guidelines, legislation, and standards
  - has undertaken required training and is approved to administer depot BPN
- ☐ The pharmacy is:
  - accredited as a current OPP provider
  - a current immunisation Program Approval holder and is approved to administer vaccinations
  - aware of relevant policy, guidelines, legislation, and standards
- ☐ The pharmacy has:
  - a consultation area which meets the requirements of a Vaccination Area in a Pharmacy Business Premises
  - adequate injection administration consumables available
  - storage facilities that comply with the *Poisons Regulations 2018* for the storage of Schedule 8 medications
  - naloxone available, for take-home and emergency use

Prior to administration

- ☐ An agreed to communication plan is in place with the prescriber
- ☐ Review client, including:
  - Confirmation of injection due date
  - Previous dose adequacy
  - Any previous adverse events
  - Client health and wellbeing
- ☐ Contact prescriber **prior to administration** (with the exception of clients presenting in opioid withdrawal) if:
  - There are immediate dosing concerns (intoxication, outside dosing window)
  - There has been a significant change in client's mental or physical health (pregnancy, severe respiratory insufficiency, hepatic insufficiency, acute alcoholism or delirium tremens)

Administration

Buvidal (Appendix D)

- ☐ Inspect vial
- ☐ Screw in plunger
- ☐ Choose site
- ☐ Prepare client for injection
- ☐ Inject dose
- ☐ Complete administration

Sublocade (Appendix E)

- ☐ Inspect vial
- ☐ Attach needle and expel air bubble
- ☐ Choose site on anterior abdomen
- ☐ Prepare client for injection
- ☐ Inject dose
- ☐ Complete administration

Post Administration

- ☐ Complete clinical notes
- ☐ Communicate with prescriber as agreed / required
- ☐ Report any adverse events to the TGA
- ☐ Confirm next dose date with client
- ☐ Observe client post administration (if required)

Appendix B – Example: Preparing an Anaphylaxis Response Kit

Source: Australian Immunisation Handbook

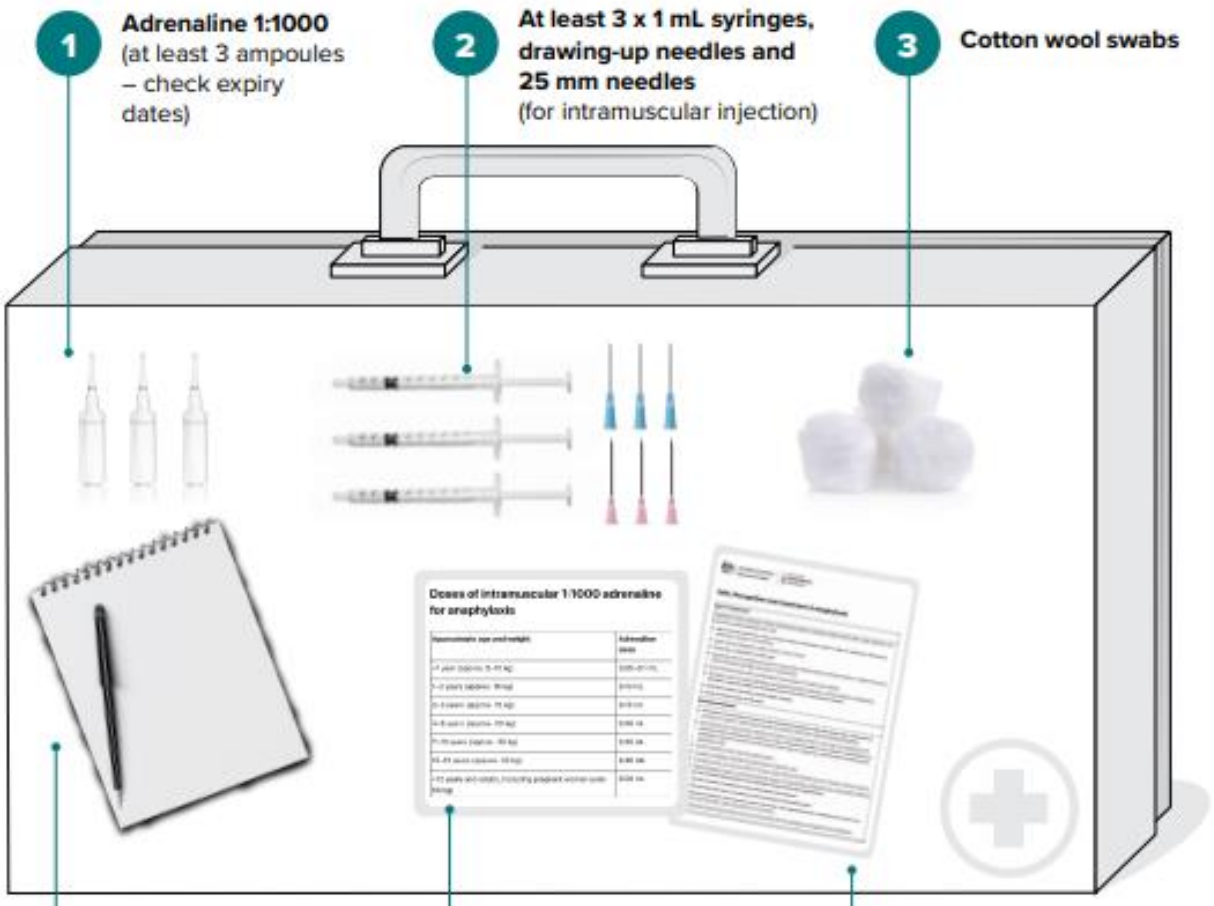
Australian Government
Department of Health

Australian **Immunisation** Handbook

Preparing an anaphylaxis response kit

! Before each vaccination session, check that you have the protocols, equipment and medicines to manage anaphylaxis.

Your anaphylaxis response kit should contain:



Keep an anaphylaxis response kit on hand at all times.
Check contents regularly to ensure they are up to date and not expired.

See the Australian Immunisation Handbook for more details.

Appendix C – Example: Anaphylaxis: Emergency Management Protocol

Source: NPS MedicineWise

Australian Prescriber

Anaphylaxis: emergency management for health professionals

Clinical features

Any acute onset of hypotension or bronchospasm or upper airway obstruction where anaphylaxis is considered possible, **even if typical skin features are not present**

OR

Any acute onset illness with typical skin features (urticarial rash or erythema/flushing, and/or angioedema) **PLUS** Involvement of respiratory, cardiovascular, or persistent severe gastrointestinal symptoms

1 Immediate action

- Call for assistance
- Lay the patient flat – do not allow them to stand or walk.
  If unconscious or pregnant, place in recovery position (left lateral if pregnant) and maintain airway.
  If breathing is difficult, allow the patient to sit with legs outstretched.
  Hold young children flat, not upright.

2 Give INTRAMUSCULAR ADRENALINE (EPINEPHRINE) into mid-lateral thigh without delay

Adrenaline dose chart (1:1000 ampoules containing 1 mg adrenaline per 1 mL)

Age (years)	Weight (kg)	Adrenaline volume 1:1000
<1	5–10	0.05–0.1 mL
1–2	10	0.1 mL
2–3	15	0.15 mL
4–6	20	0.2 mL
7–10	30	0.3 mL
10–12	40	0.4 mL
>12 and adult	>50	0.5 mL

Autoinjector

An adrenaline autoinjector, e.g. EpiPen or Anapen, may be used instead of an adrenaline ampoule and syringe.

- 150 microgram (0.15 mg) device for children 7.5–20 kg (aged ~1–5 years)
- 300 microgram (0.3 mg) device for children over 20 kg (aged ~5–12 years) and adults
- 300 microgram (0.3 mg) or 500 microgram (0.5 mg) device for children over 50 kg (aged ~>12 years) and adults

Instructions are on device labels and ASCIA Action Plans.

Repeat adrenaline every 5 minutes as needed

If multiple doses are required, consider adrenaline infusion if skills and equipment available (see step 5).

Remove allergen (if still present): flick out insect stings, freeze ticks with liquid nitrogen or ether-containing spray (if available) and allow to drop off.
ALWAYS give adrenaline FIRST, then asthma reliever puffer, if someone with known asthma and allergy to food, insects or medicine has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

3 Call ambulance to transport patient to hospital

Keep the patient flat and transfer to ambulance via stretcher. Do not allow them to stand or walk even if they appear to have recovered following administration of adrenaline.

4 Supportive management

When skills and equipment are available:

- monitor pulse, blood pressure, respiratory rate, pulse oximetry
- give oxygen and airway support if needed
- obtain intravenous access in adults and hypotensive children
- if hypotensive, give intravenous normal saline (20 mL/kg rapidly) and consider additional wide-bore intravenous access.

5 Additional measures

Adrenaline (epinephrine) infusion

If inadequate response or deterioration, start an intravenous adrenaline infusion as follows:
Give only in liaison with an appropriate specialist. Phone .....

- Mix 1 mL of 1:1000 adrenaline in 1000 mL of normal saline
- Start infusion at 5 mL/kg/hour (0.1 microgram/kg/min)
- Titrate rate according to response
- Monitor continuously

If adrenaline (epinephrine) infusion is ineffective or unavailable, also consider:

For upper airway obstruction

- nebulised adrenaline (5 mL, i.e. 5 ampoules of 1:1000)
- intubation if skills and equipment are available

For persistent hypotension/shock

- give normal saline (maximum 50 mL/kg in the first 30 min)
- in patients with cardiogenic shock (especially if taking beta blockers) consider an intravenous glucagon bolus of 1–2 mg in adults (in children: 20–30 micrograms/kg up to 1 mg). This may be repeated or followed by an infusion of 1–2 mg/hour in adults
- in adults, selective vasoconstrictors metaraminol (2–10 mg) or argipressin (vasopressin) (10–40 units) only after advice from an appropriate specialist

For persistent wheeze

- bronchodilators: salbutamol 8–12 puffs of 100 micrograms using a spacer or 5 mg salbutamol by nebuliser
- oral prednisolone 1 mg/kg (maximum 50 mg) or intravenous hydrocortisone 5 mg/kg (maximum 200 mg)

6 Observation

Prolonged and biphasic reactions may occur.

Observe the patient for at least 4 hours after last dose of adrenaline.

Observe longer (overnight) if the patient:

- had a severe reaction (hypotension or hypoxia), or
- required repeated doses of adrenaline, or
- has a history of asthma or protracted anaphylaxis, or
- has other concomitant illness, or
- lives alone or is remote from medical care, or
- has known systemic mastocytosis.

Document food, medicine, sting/bite exposure in the 2–4 hours before anaphylaxis.

7 Follow-up treatment

Corticosteroids

The role of corticosteroids is unknown. It is reasonable to prescribe a 2-day course of oral steroid (e.g. prednisolone 1 mg/kg, maximum 50 mg daily) to reduce the risk of symptom recurrence after a severe reaction or a reaction with marked or persistent wheeze. Corticosteroids should only be administered after adrenaline and resuscitation.

Adrenaline (epinephrine) autoinjector

Prescribe an autoinjector, pending specialist review. Train the patient in autoinjector use and give them an ASCIA Action Plan for Anaphylaxis - www.allergy.org.au.

Allergy specialist

Refer patients with anaphylaxis for review.

Antihistamines

Antihistamines have no role in treating respiratory or cardiovascular symptoms of anaphylaxis. Oral non-sedating antihistamines treat itch and urticaria. Injectable promethazine should NOT be used in anaphylactic shock as it can worsen hypotension.

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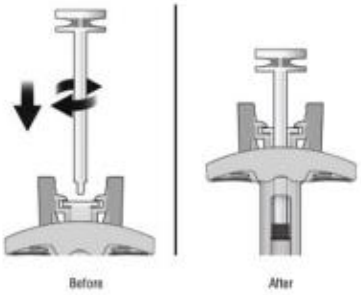
Endorsed by the Australasian College for Emergency Medicine, the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists, the Australasian Society of Clinical Immunology and Allergy (ASCIA), the Australian College of Rural and Remote Medicine, the Australian Dental Association, the Internal Medicine Society of Australia and New Zealand, and the Royal Australasian College of Physicians.
This Anaphylaxis Wallchart has been officially recognised as an Accepted Clinical Resource by the Royal Australian College of General Practitioners.

Appendix D – Buvidal® depot BPN abbreviated administration technique

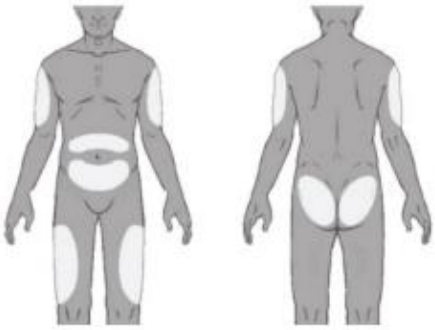
Source: The Pharmacy Guild of Australia

1. Inspect vial
    a. Expiry date?
    b. No particulates?
    c. Air bubble must not be expelled



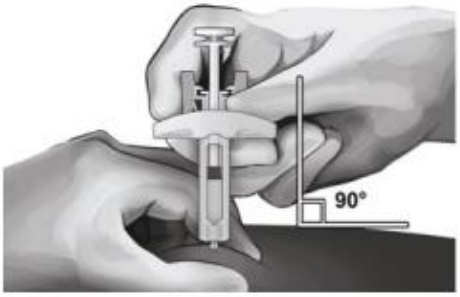
2. Screw in plunger

3. Choose site
    a. Consider client request
    b. Consider site rotation
    c. Ice pack required for pain?



4. Prepare client for injection
    a. Comfortable position for site: supine, reclining, seated or standing
    b. Sanitise site with alcohol swab (min 30 seconds to evaporate)

5. Inject dose
    a. Pinch and hold skin
    b. Insert full length of needle at 90 degrees
    c. Firmly and gently depress plunger
    d. Plunger will click into guard at full depth
    e. Remove needle at 90 degrees
    f. Sharps disposal

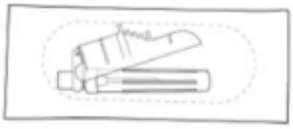


6. Complete administration
    a. Clean any blood
    b. Apply small dressing
    c. Complete records
    d. Plan next dose

Appendix E – Sublocade® depot BPN abbreviated administration technique

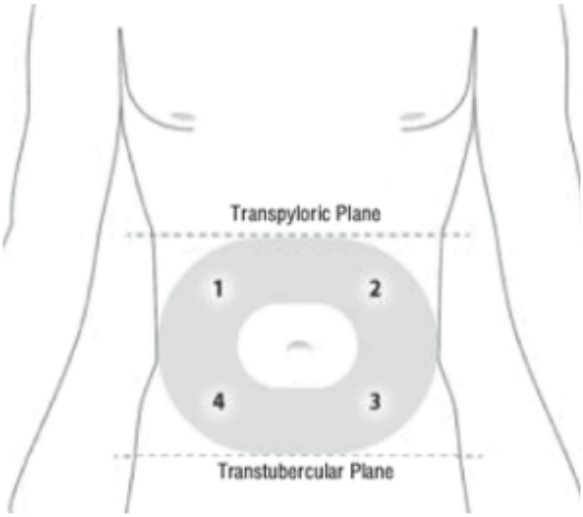
Source: The Pharmacy Guild of Australia

1. Inspect vial
    a. Expiry date?
    b. No particulates?
    c. Colour variations normal, from colourless to deep amber
    d. If in cold storage, allow 15 minutes to come to room temp



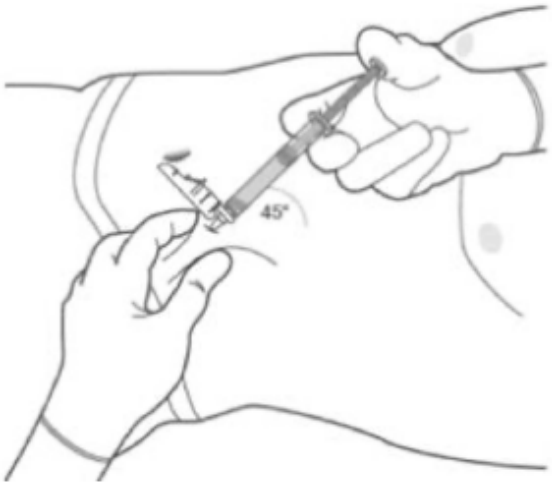
2. Attach needle and expel air bubble
    a. Using sterile technique remove rubber cap and screw on needle
    b. May draw in air to merge bubbles
    c. Slowly expel air bubble
    d. Caution not to expel drug

3. Choose site on anterior abdomen
    a. Consider site rotation
    b. Ice pack required for pain?



4. Prepare client for injection
    a. Comfortable, laying supine or reclining
    b. Sanitise site with alcohol swab (min 30 seconds to evaporate)

5. Inject dose
    a. Pinch and hold skin
    b. Insert full length of needle at 90 degrees (consider 45 degrees in lean clients)
    c. Firmly and gently depress plunger
    d. Remove needle at same angle
    e. Engage safety guard using hard surface
    f. Sharps disposal

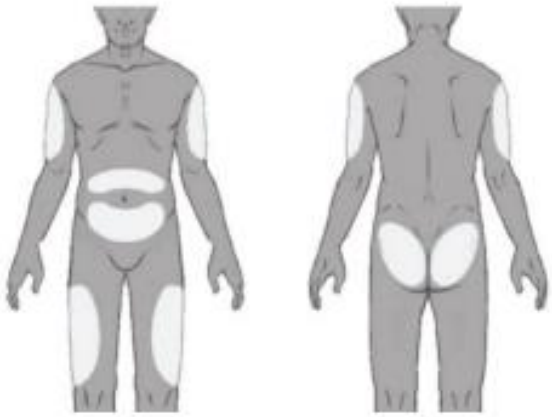
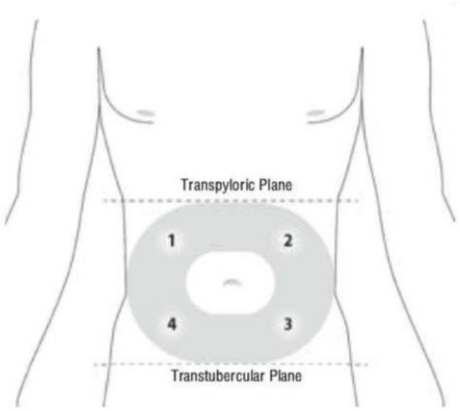


6. Complete administration
    a. Clean any blood
    b. Apply small dressing
    c. Complete records
    d. Plan next dose

Appendix F – Record Keeping Template

Reference: The Pharmacy Guild of Australia, Tasmanian Alcohol and Drug Service (ADS)

Date:	
Any known allergies:	
Client name:	Prescriber and practice name:
DOB:	
Phone:	Phone:
Script expires:	
Any issues with previous depot?	
Is the dose acceptable?	
Any injection site pain / infection / issues?	
Any opioid related issues noticed?	
Any changes to existing, or new, medications (prescribed or OTC) or vitamins / supplements since last dose?	
Any health (mental or physical) issues / changes since last dose?	
Any relevant non-health or social issues / changes since last dose?	
Any substance related issues / changes since last dose?	
Any clinical or social information the prescriber needs? Any documentation to be forwarded? Should anything be addressed before the next dose?	
Was Naloxone offered? If yes, was it provided?	
Medication name, dose, expiry date and batch number (include Naloxone if provided):	

Site dose was administered (Please use key to circle / note where dose was administered)	For Buvidal: 
	For Sublocade: 
Pharmacist signature and date:	

Development and Consultation Record *(To be completed for all protocols or guidelines)*

Development / review authorised	Dr Nicolle Ait Khelifa	Statewide Specialty Director, Alcohol and Drug Service	September 2022
Prepared by	Nina Manning	Principal Service Development Officer	September 2022
Through Custodian	Dr Nicolle Ait Khelifa	Statewide Specialty Director, Alcohol and Drug Service	20 December 2022
Initial consultation with key stakeholders	Advisory Group	Depot Buprenorphine in Pharmacy Advisory Group	20 December 2022
	Public Health Services		18 January 2023
	Mental Health Alcohol and Drug Directorate		14 February 2023
	Pharmaceutical Services Branch		7 February 2023
Content confirmed - Delegated Authority*	Dr Nicolle Ait Khelifa	Statewide Specialty Director, Alcohol and Drug Service	dd month yyyy

THS-Statewide Approval Record *(Delete table if local or regional document)*

Endorsed	THS Policy Coordination Group	THS-Statewide committee	dd month yyyy
Approved	Name of THS Executive Director	Executive Director Title	dd month yyyy
Uploaded to SDMS	Name	Position Title	dd month yyyy

**Delegated Authority – Executive Director, Director/Co-Director of Service, some Senior Managers (eg General Manager)*