PRESCRIPTION REVIEW PROGRAM

2018 Annual Report

(For the period of January 1, 2018 – December 31, 2018)

April 1, 2019

Table of Contents

Annual Report 2018

Prescription Review Program Overview

The Prescription Review Program (PRP) is an education-based program operated by the College of Physicians and Surgeons of Saskatchewan (CPSS) on behalf of the Ministry, that monitors medications with known misuse, abuse and diversion potential for possible inappropriate prescribing by physicians, and possible inappropriate use by patients. The list of medications monitored by the PRP is listed in the CPSS Regulatory Bylaw 18.1 (Appendix A) as well as in Appendix B (*Prescription Review Program Monitored Medications*). In addition, Bylaw 18.1 outlines the requirements for prescribing these medications.

The PRP staff alerts physicians of possible inappropriate prescribing or of inappropriate use of PRP medications by their patients, most commonly by letter. Depending on the situation, PRP staff may contact the physician directly by phone. The PRP staff provides supportive and/or educational information, as well as recommendations to physicians to encourage appropriate prescribing practices. In some cases, physicians are required to provide explanations for their prescribing rationale. After reviewing a physician's reply, the PRP staff may make additional recommendations regarding best practices to improve patient outcomes, or reduce the possibility of inappropriate use of medications.

Staffing and Workflow

The PRP staffing in 2018 includes:

Program Manager
The Program Manager is a Pharmacist who guides the work of the PRP, oversees program staff and supports physicians through education and recommendations related to the prescribing of PRP medications. The Program Manager also works with various stakeholder groups (e.g. FNIHB, NIHB, SCPP, Ministry of Health) to help optimize prescribing and address prescription drug abuse in Saskatchewan.

Analyst
The Analyst monitors and reviews patient medication profiles, generates reports related to specific medication use or specific prescribers, and identifies possible areas of concern. The Analyst is also the lead on law enforcement engagement, and receives and responds to public information related to the possible diversion of PRP medications.

Contract Pharmacist (January – March)
The contract pharmacist assists with responding to physician correspondence, and other PRP duties as assigned.

Administrative Assistant (role became vacant December 7, 2018)
The Administrative Assistant processes and prepares all correspondence to physicians, assists in the monitoring of patient profiles, and supports the PRP team with administrative tasks. This role is divided between the PRP and the Opioid Agonist Therapy Program.

There are numerous other roles, responsibilities and activities performed by the PRP team that vary significantly from day-to-day, depending on program demands, such as the coordination of educational events, or stakeholder requests.

Generally, the day-to-day activities of the PRP staff can be summarized as follows:

The PRP continues to focus towards a paperless workflow process and further optimized its use of the electronic document management software.

The Analyst continues to work with eHealth software developers to create a more user-friendly analytic program through the already available Micro Strategy tool. The new PRP Micro Strategy tool was released to the Analyst in test format in the fall of 2018. This new tool will allow the PRP staff to analyze data more efficiently than in the past, freeing up more time for education and outreach.

Prescription Review Program Letters

There are four categories of letters most commonly sent to physicians by the PRP: Double Doctor, Explain, Alert, and Response. These are defined in the blue box on the right-hand side of the page, and the letter counts are in the table below.

Letter Counts for 2018

Letter Type	# sent out in 2018
Educational Letters	146
Explain/Alert (1st contact)	298
2nd Request	11
Response/Recommendations	73
Law Enforcement Requests	55

Alert letters are also sent to physicians when calls are received by the PRP staff from individuals (sometimes anonymously) providing information that someone (who has been prescribed PRP medications) may possibly be misusing and/or diverting their medication. The PRP does not suggest in those letters that the physician cease prescribing to the patient. Rather, the PRP recommends that the prescriber have a conversation with the patient and put safeguards in place, if not already in place, such as treatment agreements, random urine drug testing or random tablet counts to prevent prescription drug misuse or diversion. Alert letters will also be sent to physicians when the PRP receives information from law enforcement about the potential misuse or diversion of medications.

Explain letters can be sent for a variety of reasons, but are always about possible inappropriate or sub-optimal prescribing. Common triggers that result in an explain letter include, but are not limited to:

- Double doctoring for an extended period (i.e. multiple months)
- A pattern of early refills
- Chronic use of benzodiazepines
- The combined use of a benzodiazepine and opioid
- The concurrent use of two benzodiazepines
- The concurrent use of two opioids

TYPES OF LETTERS

Alert – sent when the patient is identified as potentially misusing his/her meds (e.g. early refills, law enforcement investigation, information from public/HCP of misuse or diversion).

Explain – letters sent to physicians to get their rationale for prescribing (e.g. provide the medical indication and dosing).

Law Enforcement Request – when a patient medication profile is provided to law enforcement for an active investigation.

Prescription – letters to physicians regarding Bylaws 17.1 and 18.1 related to legibility and PRP requirements for a valid prescription.

Response/Recommendations – PRP Manager's response to a physician's explain letter response. These often contain recommendations and recommended resources.

Educational Letters – these letters contain educational information for physicians, such as guideline updates, and provide the names of the specific patients to which the information may apply to allow physicians to easily identify these individuals.

- Prescribing of large quantities of immediate-release opioids repeatedly with/without the use of a sustained-release preparation
- Prescribing of opioids and benzodiazepines for patients concurrently receiving opioid agonist therapy
- Patients with a history of unexpected urine drug screen results
- Large quantities of tablets being dispensed regularly
- Use of brand name preparations when a generic is available
- Specific medications very infrequently used (e.g. Demerol, Talwin, phenobarbital)

Once the physician provides a response to an Explain letter, the Pharmacist can assess the appropriateness of the prescribing and provide recommendations for possible medication changes or general medication management, such as random urine drug screens, random pill counts, treatment agreements, or other approaches in the **Response/Recommendations letter** sent back to the physician.

Educational letters - see Appendix J for a copy of the Ritalin educational letter that was sent to all Saskatchewan physicians in 2018.

Highlights of PRP Activities for 2018

For the activities below, the PRP team member(s) who attended are denoted by: PM – PRP Pharmacist Manager; PA – PRP Analyst; AA – PRP Administrative Assistant

Below are the PRP activities that occurred in 2018 in relation to education to various stakeholder groups, partnerships and collaborations with various stakeholder groups, as well as educational events attended.

Educational Outreach & Collaboration

- **Presentation to Saskatchewan Association of Chiefs of Police**
  - February 22 – Regina
  - PM attended

- **Presentation to RCMP Whole South District**
  - April 12 - Yorkton
  - 31 detachments – Commanders & Corporals
  - PM & Legal attended

- **The Community is the Medicine & From Wound to Wellness**
  - April 16-20 – Day Star First Nations
  - Personal and Community Wellness and Healing Workshop
  - PM attended

- **Meeting with CPSS -**
  - April 17 – T.C. Douglas, Regina
  - PHAC Public Health Officer, Dr Shahab, Kathy Willerth; Lisa Lockie
  - Section 56 exemption, take home naloxone, federal funding, OST guidelines for addiction counsellors, other
  - PM attended

- **Provincial Health Meeting to Discuss Reporting to Opioid Summit**
  - May 24 - Regina
  - Pre-meeting with Lisa Lockie re: opioid treatment emergency fund
  - PM PRP & Registrar attended

- **Saskatchewan Regional Prescription Drug Abuse Coordinating Committee**
  - May 31 – CPSS office
  - PM & PA attended

- **Law Enforcement Poster presented at FMRAC**
  - June 18 – Charlottetown, PEI
  - Sr. Legal attended

- **Opioid/Fentanyl Educational for SGEU**
  - June 18 - Regina
  - PM, Dr. Butt, Dr. Ross attended

- **Chronic Pain Management/Adult ADHD**
  - June 18 - Saskatoon
  - The 2017 Opioid Guidelines, Dr. Opdahl
  - Dr. Brennan MD FRCPC, Clinical Assistant Professor
  - PM attended

- **Summer/Fall**
  - PM - member of the *SRNA Interdisciplinary Advisory Group Opioid Use Disorder and Methadone Prescribing*

- **Presentation re methadone and Suboxone in OST**
  - Aug 29 - Kamsack
  - Dr. Markentin & Dr. Butt presented

- **Opioid Symposium**
  - September 5 & 6 – Toronto
  - PM attended
  - Presenter Concurrent Session: Innovative approaches to treatment and prevention
  - Increasing access to Substance Use Disorder Treatment and Prevention Services in Indigenous Communities
  - Link to event information: https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/responding-canada-opioid-crisis/opioid-symposium-2018.html

- **Opioid use in Saskatchewan - *We all have an important role to play***
  - September 19 - Saskatoon
  - The 11th Annual Inter-Professional Student Symposium (I-PASS)
  - PM was an invited speaker
  - Put on by Health Science Students Association (HSSA)

- **Opioid use in Saskatchewan - *We all have an important role to play***
  - October 22 – Sask Polytech, Saskatoon
  - Interprofessional Health – educators and learners
  - PM was an invited speaker

- **CRISM – Prairie Node 3rd Annual Gathering**
  - November 1 & 2 – Wanuskewan Heritage Park, Saskatoon
  - PM & PA attended

- **Prescriptions and Politics – Drug Pricing Reform & the Implementation of Pharmacare of Canada**
  - November 6 – Saskatoon (webinar)
  - PM attended

- **2018 Infoway Partnership Conference – Driving Access to Care (Canada Health Infoway) – Invited as a member of the PrescribeIT opioid working group (funded by Canada Health Infoway)**
  - November 13 & 14 - Westin Montreal
  - https://www.infoway-inforoute.ca/en/component/edocman/3456-2018-infoway-partnership-conference-program/view-document?Itemid=0
  - Followed by a PrescribeIT working groups meeting Nov 14
  - PM attended

- **Meeting re future methadone and buprenorphine/naloxone prescribers in Regina**
  - November 20 – Saskatoon
  - PM, Registrar & Deputy Registrar attended

- **SHA Opioid Stewardship Meeting with Robert Parker (RN)**
  - November 30/December 1st – Regina
  - PM attended

- **Dr. Butt and & Dr. Markentin presentation**
  - December 8 – Yorkton
  - Educational event on OAT prescribing

Other PRP activities of note that occurred in 2018 include:

- Continued collaboration with the College of Pharmacy Professionals
- Continued work with the National Advisory Council on Prescription Drug Misuse
  - Comprehensive 10-year pan-Canadian strategy released in March 2013
- Continued collaboration with the Ministry of Justice Fentanyl Opioid Overdose Task Force
- Collaboration with eHealth to redesign MicroStrategies to meet the needs of PRP
- Collaboration with the Safer Communities and Neighbourhoods (SCAN) Unit
- Collaboration with Dr. Nathaniel Osgood - Professor, Department of Computer Science; Associate Faculty, Department of Community Health & Epidemiology; Associate Faculty, Bioengineering Division – on health informatics and analysis of the PRP data
- Initiated Project ECHO (Extension for Community Healthcare Outcomes) work with Dr. Tupper and Dr. Jeffery
  - Project ECHO links expert specialist teams at an academic hub with primary care clinicians in local communities.
- Continued with the development and growth of the saskpainaddiction.com website

PRP Medication Use in Saskatchewan for 2018
Trends and Insight

An overview of the PRP medications prescribed and dispensed in Saskatchewan are available in Appendices C through F. Dispensing quantities from 2014 to 2018 were provided to allow for a comparison and to identify possible trends.

Stimulants (Methylphenidate)

Overall, there has been a decrease in **methylphenidate** (generic + brand) prescribing. Methylphenidate is one of the top three most commonly misused/abused medications encountered by the PRP. With the PRP's work with law enforcement in the province, it became obvious that the brand name medication was increasingly being used illegally, warranting active investigations at a concerning rate. In response, the PRP mailed educational resources to physicians prescribing brand name methylphenidate based on the updated Canadian ADHD Resource Alliance (CADDRA) Canadian ADHD Practice Guidelines. The letter encouraged prescribers to prescribe generic formulations due to the law enforcement concern and observation. (Appendix J)

Opioids

Fentanyl injection, available as a 50mcg/ml vial, showed a marked increase between 2015 and 2016 (153%), but then decreased substantially between 2016 and 2017. Apart from the 37mcg patch (128% increase), all other patch strengths decreased between 2017 and 2018. Fentanyl overdoses have garnered a lot of attention by the media over recent years which may contribute to reduced prescribing.

Hydromorphone 2mg/ml injection was the most frequently dispensed hydromorphone injection, as seen in previous years. The 2mg/ml strength is commonly dispensed in the community for palliative care/end-of-life symptomatic therapy. The higher strengths of oral immediate-release hydromorphone (4mg and 8mg) showed a decreased trend, with the lower strengths (1mg and 2mg) showing a slight increase in units dispensed from 2017 to 2018. For Hydromorph Contin, the sustained-release preparation of hydromorphone, all strengths showed a decrease between 2017 and 2018 except for the 4.5mg and 9mg strengths.

Morphine 10mg/ml injection, the most commonly dispensed strength, has continuously trended downward since 2014. As the opioid crisis has progressed, we've seen an increased trend for morphine solution (slight decrease between 2017 and 2018). This may be contributed to the use of morphine solution in neonatal abstinence syndrome secondary to in-utero opioid exposure. The lower strengths of Kadian have increased while the higher strengths have decreased. In certain circumstances, Kadian is prescribed during the induction phase of OAT. Additionally, some prescribers are using it during the transition from methadone to buprenorphine/naloxone.

In all 3 strengths of **oxycodone** immediate-release, there has been a decreased trend in dispensing between 2017 and 2018. Similarly, for the sustained-release formulation, except for the 15mg tablets, there has also been a downward trend. As a result, there has been a 17% decrease in oral morphine

equivalents with the IR formulation and a decrease of 11% in oral morphine equivalents with the SR formulation between 2017 and 2018.

Of the **acetaminophen/codeine** combination products analyzed, Tylenol No. 2, No. 3 and No. 4, Tylenol No. 3 continues to be the most commonly dispensed product. Overall, dispensing appears somewhat consistent for the three combination products over the years with an increase (22%) in Tylenol No. 2 and a slight decrease (4%) in Tylenol No. 3 between 2017 and 2018.

Gabapentin

Gabapentin 300mg capsules were the most commonly dispensed strength of capsules, with units dispensed between 2017 and 2018 remining fairly constant (1.5% difference). There have been significant back orders for various strengths of gabapentin, often requiring inadvertent dose modifications in prescribing (e.g. when the 600mg tablets were unavailable, prescribers had to use 2 x 300mg capsules).

Benzodiazepines

Clonazepam, a long acting benzodiazepine (BZ) continues to be the most commonly dispensed benzodiazepine. Of the benzodiazepines in Appendix F (alprazolam, clonazepam, diazepam, lorazepam, oxazepam and temazepam), clonazepam is the only one that depicts an increase in dispensed oral diazepam equivalents between 2017 and 2018.

Opioid-Associated Deaths

Although data is preliminary and currently inconclusive due to ongoing investigations, there have been 87 reported opioid related deaths for 2018 (70 accidental, 16 suicide, 1 undetermined).

Number-wise, opioid related deaths appear to have remained fairly constant up until 2015 at which time there was a notable increase. Between 2014 and 2015, there was an increase of 24 opioid related accidental deaths, 10 opioid related suicidal deaths and 2 opioid related undetermined deaths. Since this initial increase in 2015, unfortunately, the number of opioid-related deaths has remained constant.

As society responds to the multi-faceted opioid crisis which is taking lives every day, our ongoing predicament will not be combated by a single approach but rather, an amalgamation of multi-disciplinary, evidence-based methodologies. The *Prescription Review Program* remains dedicated to providing educational support to physicians throughout the province for optimizing patient outcomes by promoting the safe and appropriate prescribing of all PRP drugs in congruence with the Canadian standards and guidelines to prevent misuse.

Appendix A: CPSS Regulatory Bylaw 18.1

18.1 The Prescription Review Program

(a) Panel of Monitored Drugs – The Prescription Review Program shall apply to all dosage forms of the following drugs, except where indicated otherwise:

ACETAMINOPHEN WITH CODEINE - in all dosage forms except those containing 8 mg or less of codeine

ACETYLSALICYLIC ACID (ASA) WITH CODEINE - in all dosage forms except those containing 8 mg or less of codeine

AMPHETAMINES - in all dosage forms

ANABOLIC STEROIDS ANILERIDINE

BARBITUATES

BENZODIAZEPINES – in all dosages and forms

BUPRENORPHINE – in all dosages and forms

BUTALBITAL - in all dosage forms

BUTALBITAL WITH CODEINE - in all dosage forms

BUTORPHANOL

CHLORAL HYDRATE

COCAINE - in all dosage forms

CODEINE - as the single active ingredient, or in combination with other active ingredients, in all dosage forms except those containing 20 mg per 30 ml or less of codeine in liquid for oral administration

DIETHYLPROPION - in all dosage forms

FENTANYL - in all dosage forms

GABAPENTIN

HYDROCODONE - DIHYDROCODEINONE - in all dosage forms

HYDROMORPHONE - DIPHRYDROMORPHONE - in all dosage forms

LEVORPHANOL - in all dosage forms

MEPERIDINE - PETHIDINE - in all dosage forms

METHADONE - in all dosage forms

METHYLPHENIDATE - in all dosage forms

MORPHINE - in all dosage forms

NORMETHANDONE-P-HYDROXYEPHEDRINE - in all dosage forms

OXYCODONE - as the single active ingredient or in combination with other active ingredients in all dosage forms

OXYMORPHONE

PANTOPON - in all dosage forms

PENTAZOCINE - in all dosage forms

PHENTERMINE - in all dosage forms

PROPOXYPHENE - in all dosage forms

b) Prescriptions for drugs covered by the Prescription Review Program shall be issued by physicians according to the policies and procedures agreed to and amended from time to time by the College of Dental Surgeons of Saskatchewan, the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Registered Nurses Association and the Saskatchewan College of Pharmacists.

(c) In order to prescribe a drug to which the Prescription Review Program applies, physicians shall complete a written prescription which meets federal and provincial legal requirements and includes the following:

(i) The patient's date of birth;

(ii) The patient's address;

(iii) The total quantity of medication prescribed, both numerically and in written form;

(iv) The patient's health services number; and,

(v) The prescriber's name and address.

(d) For the purpose of this bylaw, "written prescription" includes an electronic prescription that meets the requirements for electronic prescribing under the Pharmaceutical Information Program.

(e) A physician who prescribes a drug to which the Prescription Review Program applies, and who provides the prescription directly to a pharmacy by electronic prescribing, by email or by FAX, or who transmits a prescription in accordance with the policies and protocols of the Pharmaceutical Information Program, need not include both the quantity numerically and in written form.

(f) If a physician is registered on the Educational Register, the physician shall, in addition to the information in paragraph (c) above, include the following in a prescription for a drug to which the Prescription Review Program applies:

(i) The training level of the physician writing the prescription;

(ii) The legibly printed name of the Most Responsible Physician (the physician to whom queries regarding the prescription should be addressed);

(iii) The legibly printed name of the physician writing the prescription.

(g) Physicians shall only prescribe part-fills of medications to which the Prescription Review Program applies if the following information is specified in the prescription:

(i) The total quantity;

(ii) The amount to be dispensed each time; and

(iii) The time interval between fills.

(h) The office of the Registrar may gather and analyze information pertaining to the prescribing of medications to which the Prescription Review Program applies in Saskatchewan for the purpose of

limiting the inappropriate prescribing and inappropriate use of such drugs. In order to fulfill that role, the office of the Registrar may, among other activities:

(i) Generally, provide education to physicians in order to encourage appropriate prescribing practices by physicians registered by the College;

(ii) Alert physicians to possible inappropriate use of medications to which the Prescription Review Program applies by patients to whom they have prescribed such drugs;

(iii) Alert physicians to possible inappropriate prescribing of medications to which the Prescription Review Program applies;

(iv) Make recommendations to a physician with respect to the physician's prescribing of medications to which the Prescription Review Program applies;

(v) Require physicians to provide explanations for their prescribing of medications to which the Prescription Review Program applies. In making requests for explanations, the office of the Registrar may require the physician to provide information about the patient, the reasons for prescribing to the patient, and any knowledge which the physician may have about other narcotics or controlled drugs received by the patient;

(vi) Cause information, concerns or opinions of general application to the profession to be communicated to the physicians registered by the College without identifying the particular physician to whom such information relates;

(vii)Provide information gathered in connection with the Prescription Review Program to another health professional body including the College of Dental Surgeons of Saskatchewan, the Saskatchewan College of Pharmacists or the Saskatchewan Registered Nurses Association, provided the information gathered is required by that body to perform and carry out the duties of that health professional body pursuant to an Act with respect to regulating the profession. Where the personal health information relates to a member of the health professional body seeking disclosure, disclosure by the Registrar of that information may only be made in accordance with The Health Information Protection Act, and in particular section 27(5) of that Act.

(i) Physicians shall respond to such requests for explanation, as described in paragraph (h)(v) above, from the office of the Registrar within 14 days of receipt of such a request for information.

(j) The Registrar, Deputy Registrar, or Prescription Review Program Supervisor may extend the deadline for reply at their discretion, upon receipt of a written request for extension from the physician.

(k) All physicians who receive such a request for information will comply, to the best of their ability, fully and accurately with such requests for information.

(l) Failure to comply with paragraphs (h)(v), (i) and (k) above is unbecoming, improper, unprofessional or discreditable conduct.

(m) Members shall keep a record of all drugs to which the Prescription Review Program applies that are purchased or obtained for the member's practice and a record of all such drugs administered or furnished to a patient in or out of the physician's office, showing:

(i) the name, strength and quantity of the drug purchased or obtained;

(ii) the name, strength, dose and quantity of the drug administered or furnished;

(iii) the name and address of the person to whom it was administered or furnished, and, if applicable, the name and address of the person who took delivery of the drug; and

(iv) the date on which the drug was obtained and the date(s) on which the drug was administered, furnished or otherwise disposed of.

(n) The record referred to in paragraph (m) shall be kept separate from the patient's medical record.

Appendix B: Prescription Review Program Monitored Medications

The following section lists the chemical name of the monitored medication, the type of dosage form that is monitored, and all the tradename (or brand name) products that are currently available.

ACETAMINOPHEN WITH CODEINE - in all dosage forms except those containing 8mg or less of codeine

- EXCLUDES: Tylenol #1, Mersyndol
- Tylenol #2
- Tylenol #3
- Tylenol #4

ACETYLSALICYLIC ACID (ASA) WITH CODEINE - in all dosage forms except those containing 8 mg or less of codeine

- EXCLUDES: 222
- 282
- 292

AMPHETAMINES - in all dosage forms

- Adderall XR
- Dexedrine
- Vyvanse

ANABOLIC STEROIDS (testosterone)

- Andriol
- Androgel
- Testim
- Androderm
- Delatestryl

ANILERIDINE - in all dosage forms

BARBITUATES

- Phenobarbital

BENZODIAZEPINES – in all dosages and forms

- Alprazolam (Xanax)
- Bromazepam (Lectopam)
- Chlordiazepoxide
- Clonazepam (Rivotril)
- Clorazepate

- Diazepam (Valium)
- Flurazepam
- Lorazepam (Ativan)
- Nitrazepam (Mogadon)
- Oxazepam
- Temazepam (Restoril)
- Triazolam

BUPRENORPHINE – in all dosages and forms

- Butran Patch
- Suboxone (naloxone combo product)

BUTALBITAL - in all dosage forms **& BUTALBITAL WITH CODEINE** - in all dosage forms

- Fiorinal, Fiorinal C1/2, Fiorinal C1/4 (ASA, caffeine, codeine [15mg or 30mg], butalbital)

BUTORPHANOL

CHLORAL HYDRATE

COCAINE - in all dosage forms

CODEINE - as the single active ingredient, or in combination with other active ingredients, in all dosage forms except those containing 20 mg per 30 ml or less of codeine in liquid for oral administration

Controlled-release:

- Codeine Contin

DIETHYLPROPION - in all dosage forms

FENTANYL - in all dosage forms

- Duragesic patch
- Onsolis buccal film (cancelled post market)
- Abstral sublingual
- Fentora sublingual

GABAPENTIN

- Neurontin

HYDROCODONE - DIHYDROCODEINONE - in all dosage forms

- Dalmacol
- Hycodan
- Tussionex

HYDROMORPHONE - DIPHRYDROMORPHONE - in all dosage forms

Immediate-release:

- Dilaudid

Controlled-release:

- Hydromorph-Contin

LEVORPHANOL - in all dosage forms

MEPERIDINE - PETHIDINE - in all dosage forms

- Demerol

METHADONE - in all dosage forms

- Metadol

METHYLPHENIDATE - in all dosage forms

- Ritalin & Ritalin SR
- Biphentin
- Concerta

MORPHINE - in all dosage forms

Immediate-release:

- M.O.S.
- MS-IR
- Statex

Controlled-release:

- MS Contin
- MOS-SR
- M-Eslon
- Kadian

NORMETHANDONE-P-HYDROXYEPHEDRINE - in all dosage forms

OXYCODONE - as the single active ingredient or in combination with other active ingredients in all dosage forms

Immediate-release:

- OXY-IR
- Supeudol

Controlled-release:

- OxyNEO

OXYMORPHONE

PANTOPON - in all dosage forms

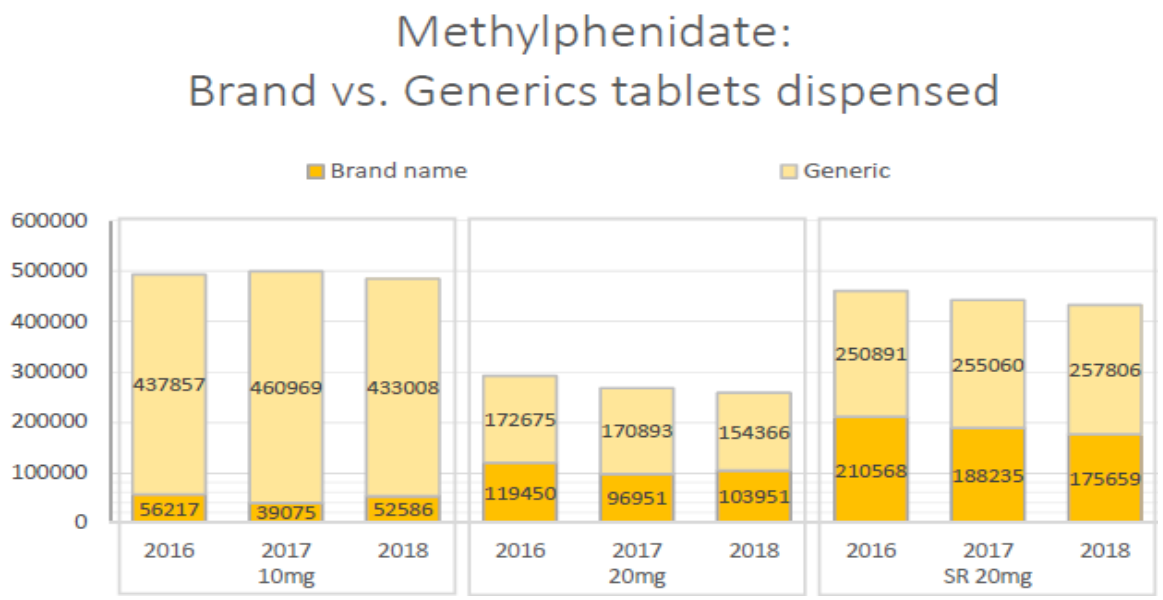
PENTAZOCINE - in all dosage forms

- Talwin

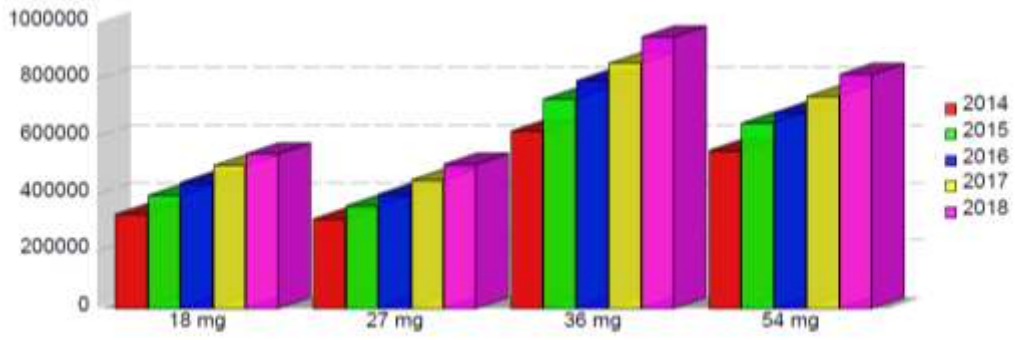
PHENTERMINE - in all dosage forms

PROPOXYPHENE - in all dosage forms

Appendix C: Stimulants



Concerta

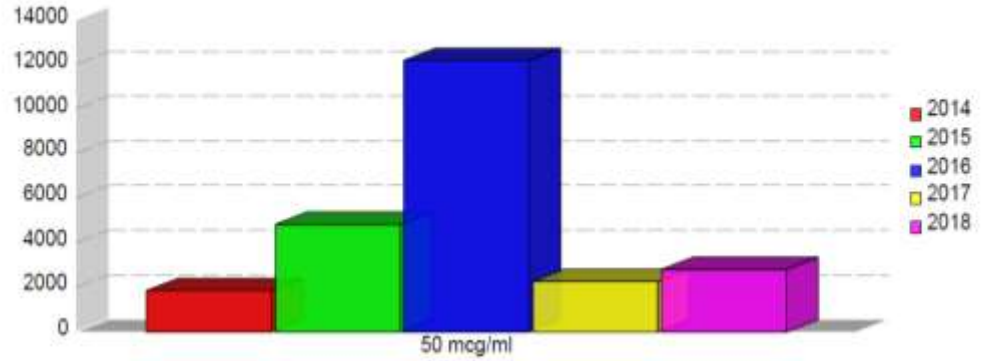


	18 mg	27 mg	36 mg	54 mg
2014	327,475	311,612	618,331	550,850
2015	393,852	356,979	730,760	646,201
2016	439,109	398,191	794,116	683,384
2017	497,578	447,769	855,272	739,515
2018	538,831	502,565	947,351	816,511

	2014	2015	2016	2017	2018
Defined Daily Dose	2,210,463	2,597,666	2,804,868	3,058,992	3,382,148

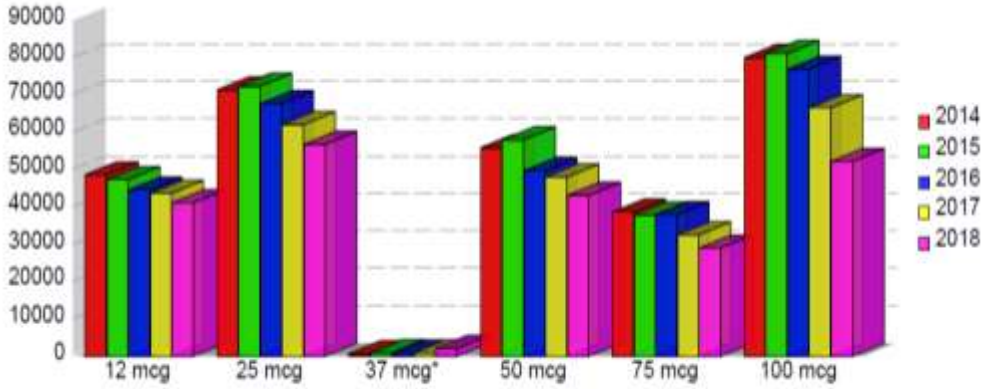
Appendix D: Opioids

Fentanyl Citrate Injection



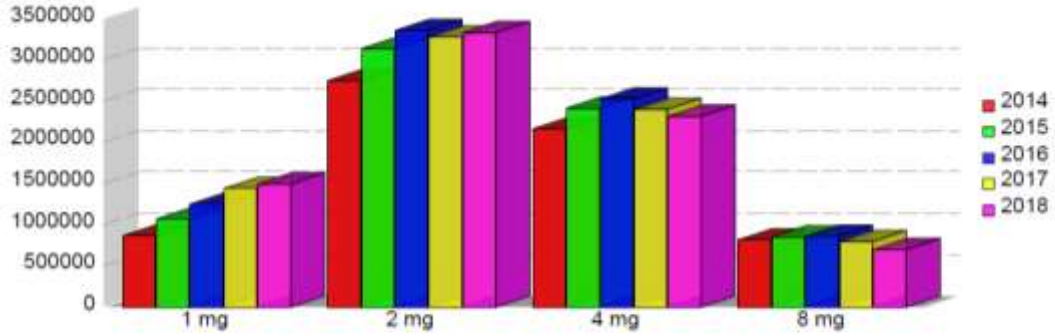
	50 mcg/ml
2014	1,849
2015	4,818
2016	12,166
2017	2,256
2018	2,800

Fentanyl Patch



	12 mcg	25 mcg	37 mcg*	50 mcg	75 mcg	100 mcg
2014	48,525	71,185	672	55,753	38,565	79,843
2015	47,255	72,185	951	57,868	37,771	80,963
2016	44,445	67,567	870	49,644	37,887	76,775
2017	43,600	61,952	926	47,967	32,486	66,457
2018	41,079	56,682	2,110	43,052	28,934	52,136

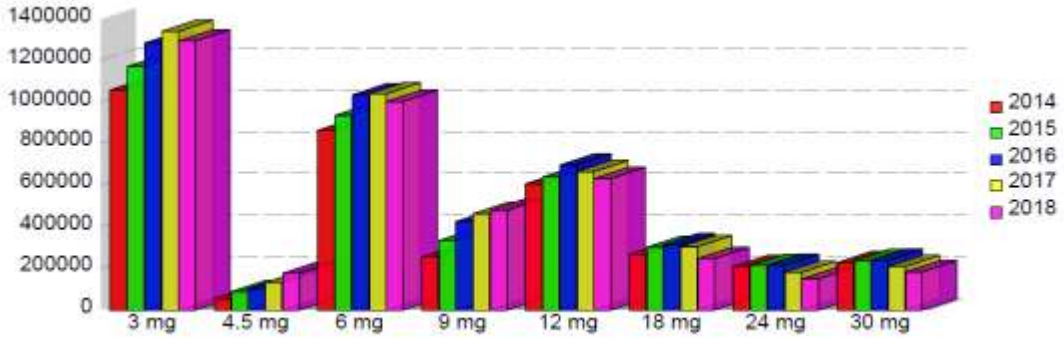
Hydromorphone IR



	1 mg	2 mg	4 mg	8 mg
2014	861,856	2,741,436	2,157,530	813,502
2015	1,066,816	3,130,508	2,409,173	849,367
2016	1,247,099	3,350,440	2,522,429	858,388
2017	1,436,957	3,272,011	2,395,275	794,761
2018	1,492,379	3,324,934	2,313,593	697,623

	2014	2015	2016	2017	2018
Oral Morphine Equivalent	3,580,477	3,959,910	4,150,800	3,986,695	3,829,601

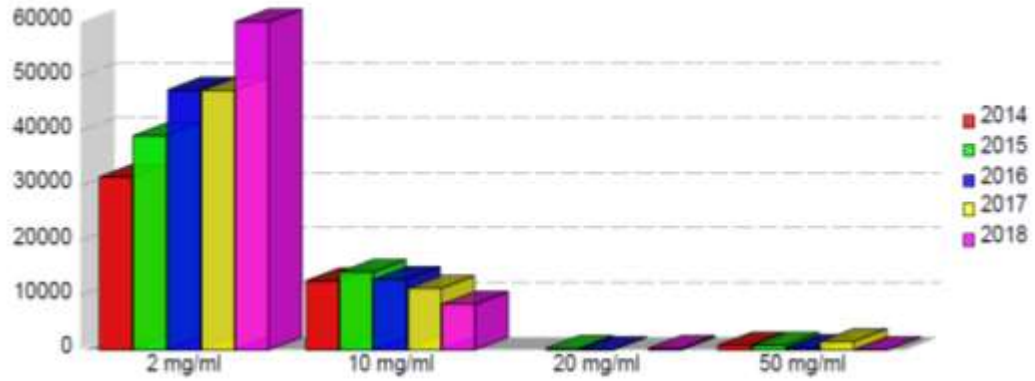
Hydromorphone Contin



	3 mg	4.5 mg	6 mg	9 mg	12 mg	18 mg	24 mg	30 mg
2014	1,057,140	55,650	863,562	254,691	606,063	268,255	208,564	227,415
2015	1,169,801	88,026	934,852	333,440	638,661	300,759	213,702	236,922
2016	1,282,031	103,773	1,033,136	424,814	696,110	313,560	214,552	239,531
2017	1,338,478	131,774	1,038,523	462,857	664,665	304,078	180,446	208,496
2018	1,292,842	176,141	1,001,915	478,984	631,514	247,681	149,701	183,328

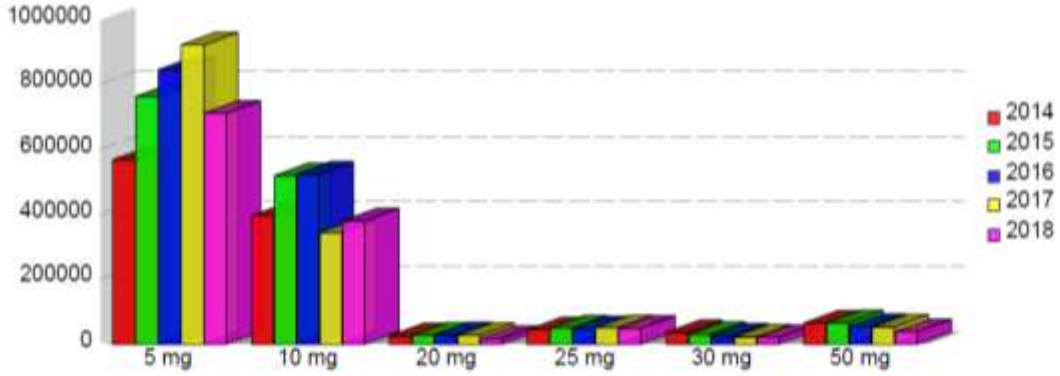
	2014	2015	2016	2017	2018
Oral Morphine Equivalent	5,804,128	6,304,949	6,777,965	6,506,706	6,020,433

Hydromorphone Injection



	2 mg/ml	10 mg/ml	20 mg/ml	50 mg/ml
2014	31,567	12,585		865
2015	39,116	14,169	250	848
2016	47,472	12,865	50	403
2017	47,382	11,214		1,530
2018	59,944	8,325	250	30

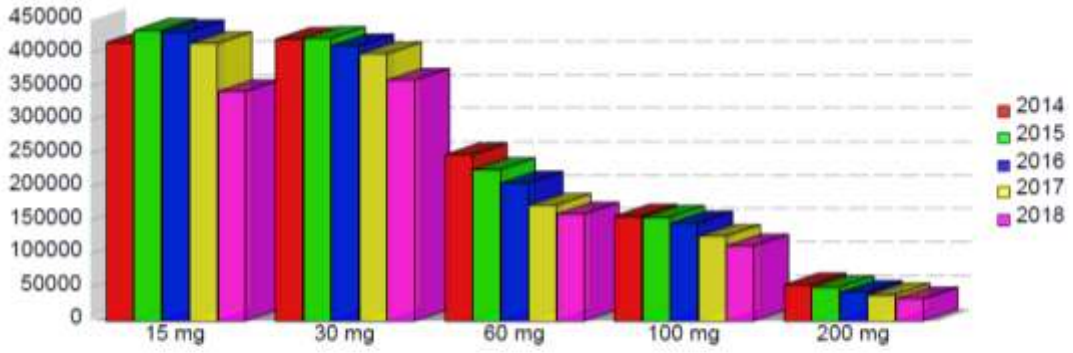
Morphine IR



	5 mg	10 mg	20 mg	25 mg	30 mg	50 mg
2014	567,088	394,093	24,707	43,393	34,538	63,976
2015	761,945	517,487	26,813	48,987	29,373	65,331
2016	844,000	522,623	27,933	46,834	23,878	54,068
2017	920,656	342,214	26,409	49,702	21,185	51,860
2018	710,373	378,817	16,492	47,854	19,471	37,368

	2014	2015	2016	2017	2018
Oral Morphine Equivalent	419,676	496,442	486,516	434,157	377,292

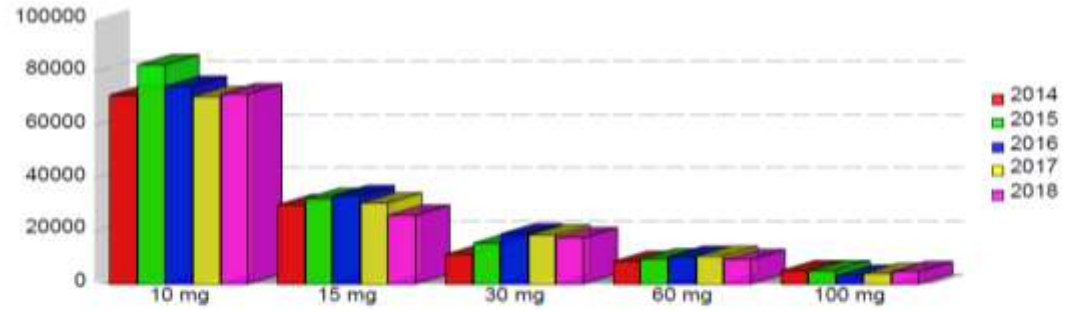
Morphine SR – 12 hour



	15 mg	30 mg	60 mg	100 mg	200 mg
2014	416,042	420,846	248,428	156,554	54,023
2015	434,185	422,136	226,153	154,781	50,156
2016	431,939	411,319	205,960	146,384	42,672
2017	414,430	398,996	172,794	126,578	38,829
2018	342,787	359,852	159,765	112,242	33,109

	2014	2015	2016	2017	2018
Oral Morphine Equivalent	2,007,723	1,941,845	1,811,635	1,632,586	1,445,842

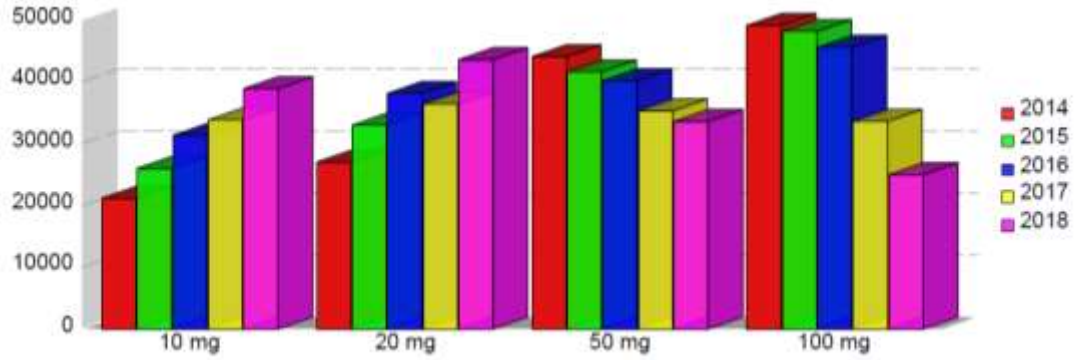
M-Eslon



	10 mg	15 mg	30 mg	60 mg	100 mg
2014	71,265	29,856	11,133	8,445	4,954
2015	82,681	32,278	15,354	9,433	4,930
2016	74,600	33,325	18,871	10,329	3,235
2017	70,749	30,570	18,468	10,440	3,938
2018	71,737	25,976	17,432	9,190	4,626

	2014	2015	2016	2017	2018
Oral Morphine Equivalent	83,219	94,353	91,842	91,343	88,132

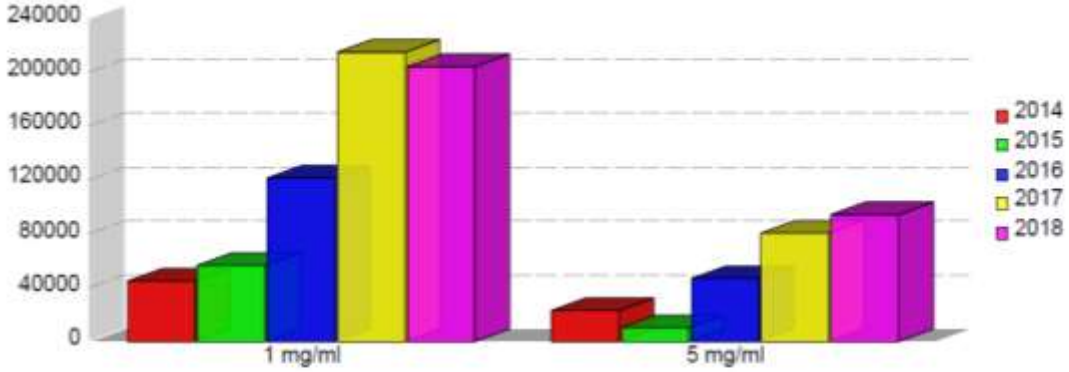
Kadian Morphine SR – 24 hour



	10 mg	20 mg	50 mg	100 mg
2014	21,144	26,975	44,011	49,061
2015	25,965	32,952	41,565	48,098
2016	31,283	38,090	40,163	45,541
2017	33,802	36,361	35,267	33,573
2018	38,850	43,542	33,561	24,950

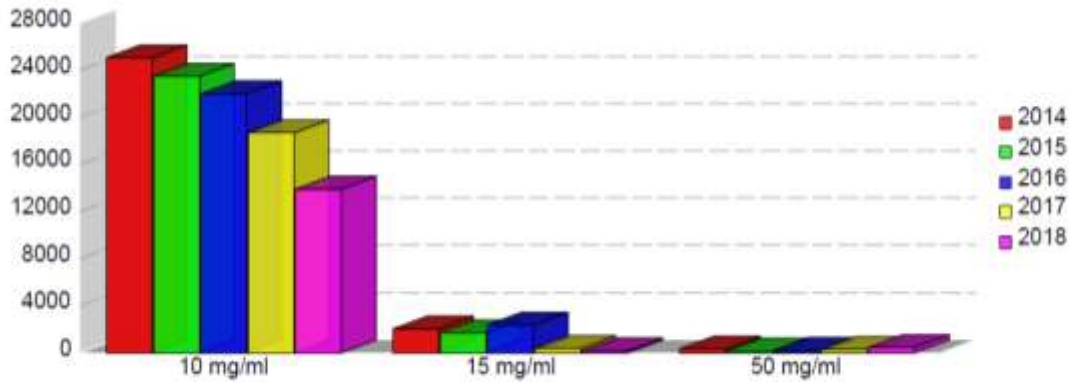
	2014	2015	2016	2017	2018
Oral Morphine Equivalent	261,920	260,225	254,563	208,196	181,080

Morphine Solution



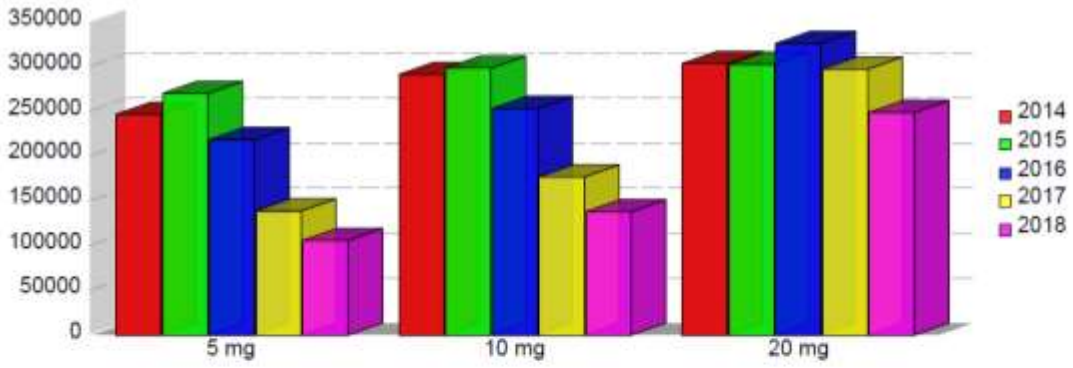
	1 mg/ml	5 mg/ml
2014	44,753	22,992
2015	56,510	10,295
2016	121,343	46,597
2017	214,739	80,455
2018	204,013	94,212

Morphine Injection



	10 mg/ml	15 mg/ml	50 mg/ml
2014	25,019	2,018	322
2015	23,447	1,701	160
2016	21,966	2,359	200
2017	18,650	372	280
2018	13,881	177	454

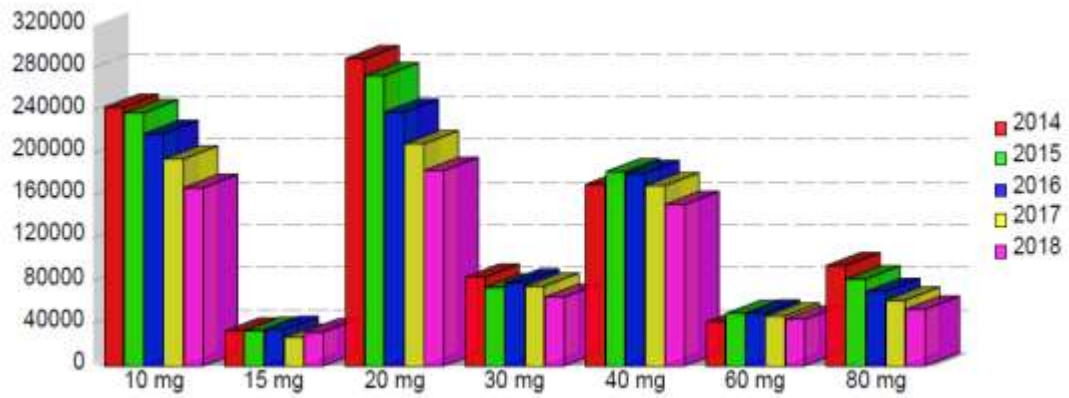
Oxycodone IR



	5 mg	10 mg	20 mg
2014	246,099	290,629	302,890
2015	269,515	297,752	302,137
2016	218,099	252,881	325,262
2017	138,613	176,546	296,664
2018	105,600	137,697	248,334

	2014	2015	2016	2017	2018
Oral Morphine Equivalent	509,729	518,302	506,227	419,590	343,583

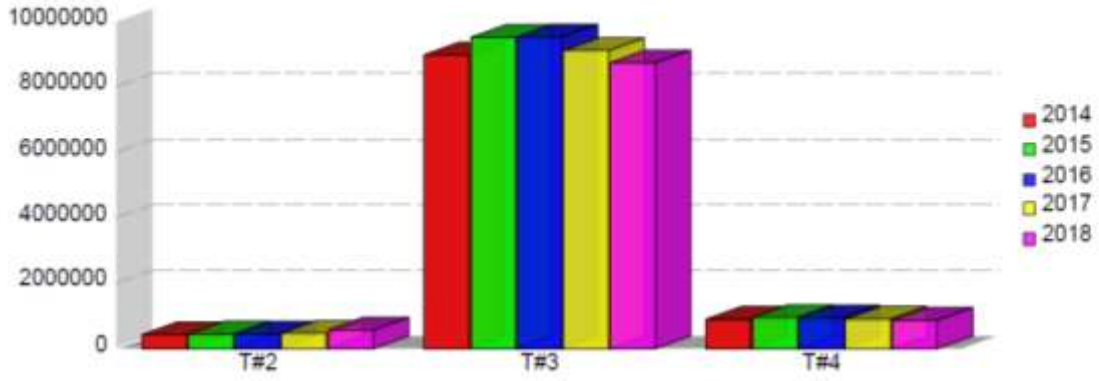
Oxycodone SR



	10 mg	15 mg	20 mg	30 mg	40 mg	60 mg	80 mg
2014	242,555	32,610	288,247	83,314	170,474	41,126	94,030
2015	237,541	33,093	272,427	73,914	182,175	49,046	81,462
2016	217,976	34,062	238,289	78,350	180,539	49,524	69,760
2017	194,218	26,819	208,450	74,777	169,116	46,731	61,672
2018	167,356	31,925	183,561	64,556	151,559	43,781	53,165

	2014	2015	2016	2017	2018
Oral Morphine Equivalent	1,399,399	1,364,224	1,279,039	1,162,952	1,035,138

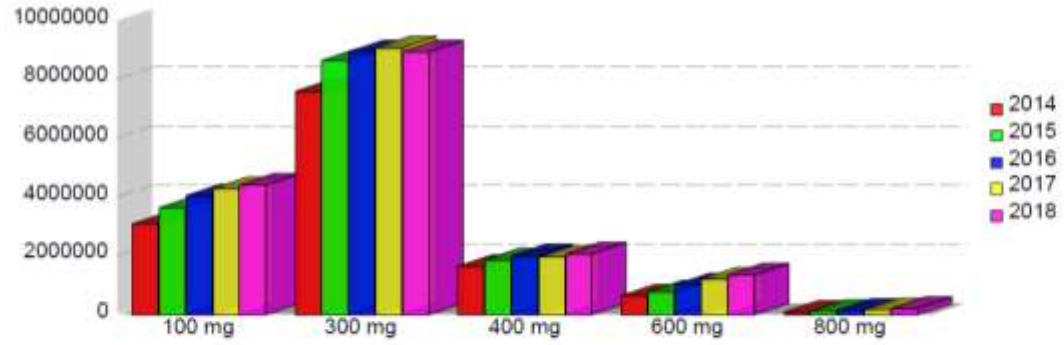
Tylonol with codeine



	T#2	T#3	T#4
2014	428,117	8,959,140	898,835
2015	448,517	9,491,856	953,037
2016	447,777	9,511,357	942,535
2017	468,081	9,092,773	904,470
2018	570,333	8,719,452	869,712

Appendix E: Gabapentin

Gabapentin



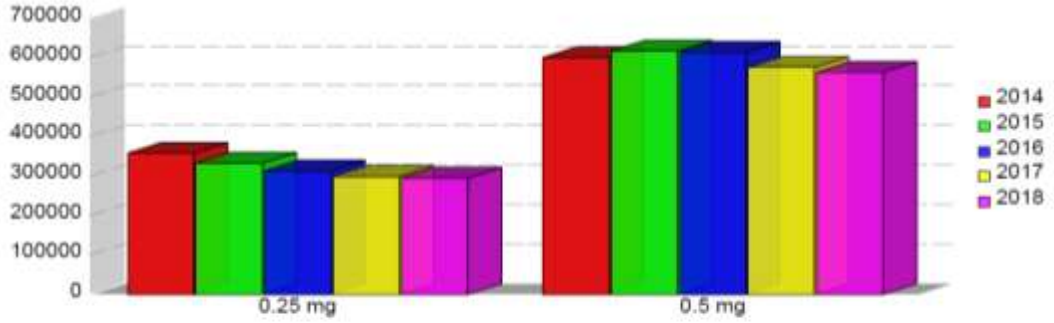
	100 mg	300 mg	400 mg	600 mg	800 mg
2014	3,076,624	7,570,181	1,638,692	636,053	78,887
2015	3,622,175	8,623,658	1,857,413	769,762	110,354
2016	4,031,023	8,916,782	1,999,905	1,008,320	151,045
2017	4,272,001	9,051,234	1,952,939	1,202,260	165,204
2018	4,398,036	8,916,695	2,062,963	1,350,962	209,219

	2014	2015	2016	2017	2018
Defined Daily Dose	2,043,853	2,356,900	2,557,737	2,654,036	2,732,194

*Defined by the WHO

Appendix F: Benzodiazepines

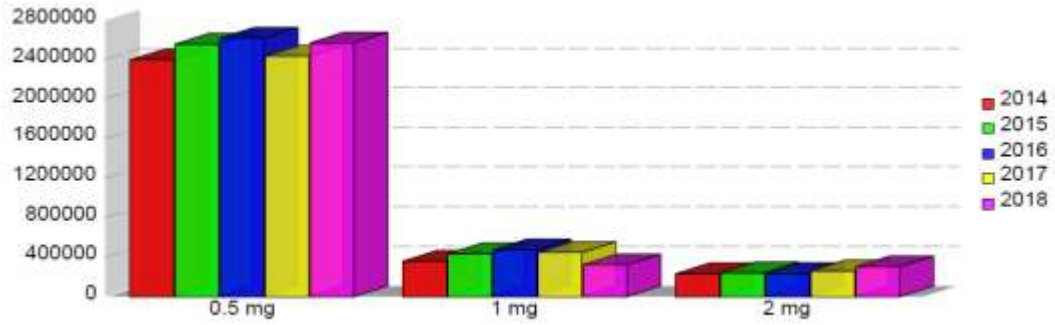
Alprazolam



	0.25 mg	0.5 mg
2014	357,366	599,108
2015	332,134	616,091
2016	312,754	613,150
2017	298,706	574,571
2018	294,428	562,585

	2014	2015	2016	2017	2018
Oral Diazepam Equivalent	777,791	782,158	769,527	723,024	709,799

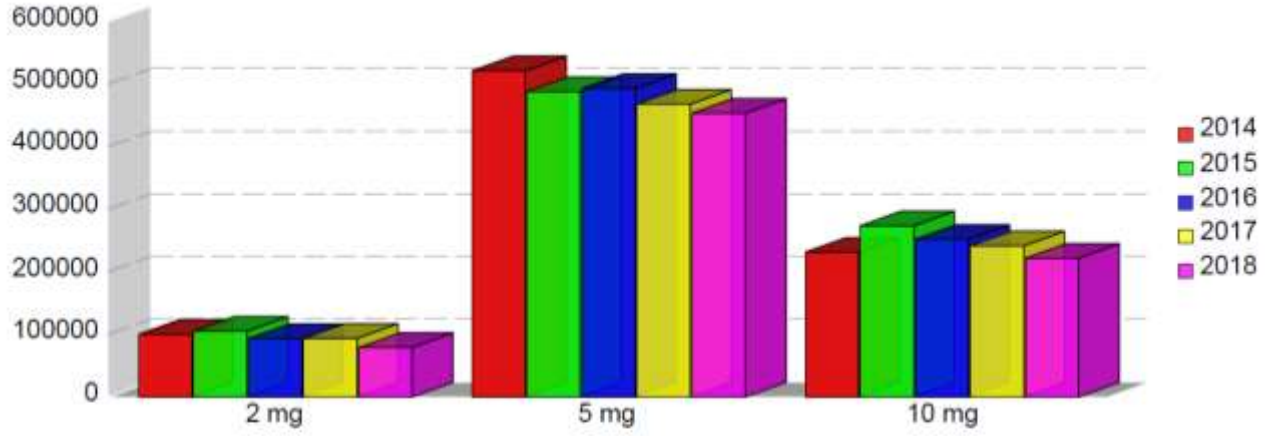
Clonazepam



	0.5 mg	1 mg	2 mg
2014	2,393,344	358,765	232,357
2015	2,554,044	434,064	241,570
2016	2,614,363	473,524	234,213
2017	2,431,347	446,285	261,569
2018	2,566,772	322,818	303,462

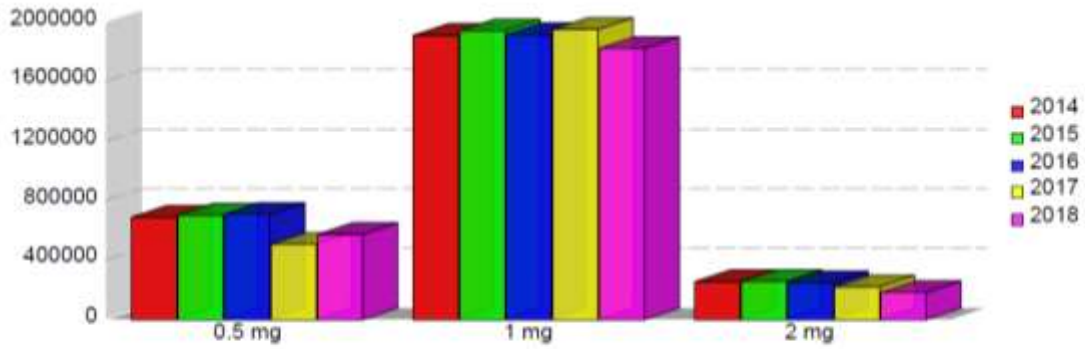
	2014	2015	2016	2017	2018
Oral Diazepam Equivalent	4,040,302	4,388,452	4,498,263	4,370,193	4,426,256

Diazepam



	2 mg	5 mg	10 mg
2014	99,939	520,523	231,007
2015	105,096	487,334	273,176
2016	93,258	492,198	251,520
2017	93,652	467,343	241,151
2018	78,950	452,866	221,328

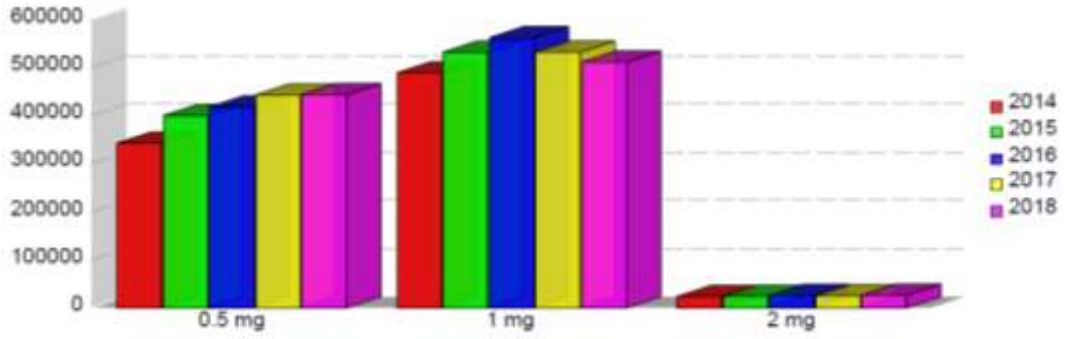
Lorazepam



	0.5 mg	1 mg	2 mg
2014	686,984	1,906,706	254,725
2015	701,259	1,937,747	256,232
2016	706,648	1,912,227	247,349
2017	585,650	1,947,151	219,532
2018	571,659	1,818,535	182,780

	2014	2015	2016	2017	2018
Oral Diazepam Equivalent	2,759,648	2,800,841	2,760,249	2,639,040	2,469,925

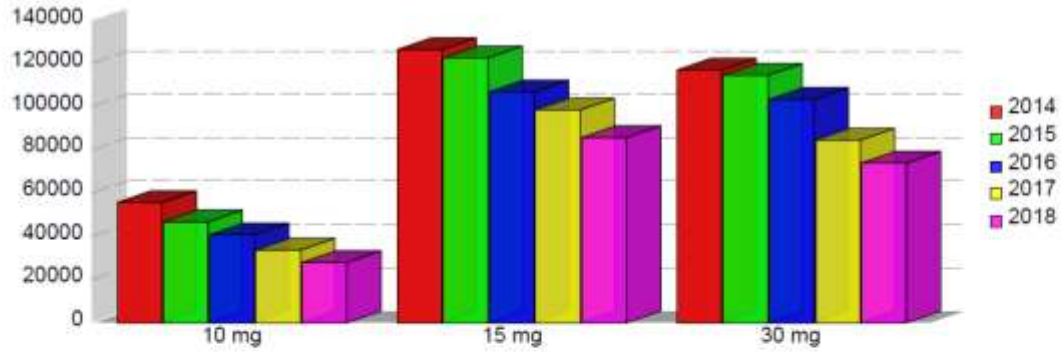
Lorazepam SL



	0.5 mg	1 mg	2 mg
2014	342,291	488,589	23,424
2015	399,377	531,477	23,930
2016	417,556	561,465	25,859
2017	442,596	531,597	25,255
2018	443,288	511,057	26,458

	2014	2015	2016	2017	2018
Oral Diazepam Equivalent	706,583	779,026	821,961	803,405	785,617

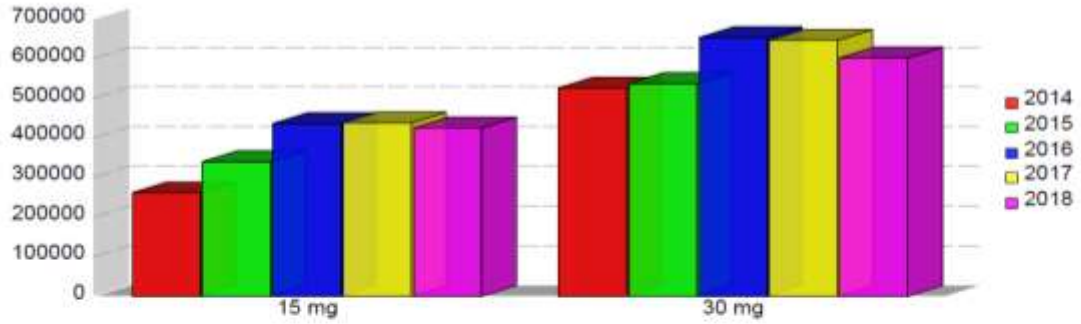
Oxazepam



	10 mg	15 mg	30 mg
2014	55,608	126,268	116,838
2015	46,709	122,477	114,486
2016	40,684	106,769	103,315
2017	33,642	98,473	84,514
2018	27,873	85,648	73,887

	2014	2015	2016	2017	2018
Oral Diazepam Equivalent	297,762	286,941	255,391	217,447	189,003

Temazepam



	15 mg	30 mg
2014	261,271	525,852
2015	339,955	537,283
2016	436,130	653,032
2017	437,928	646,210
2018	425,185	601,926

	2014	2015	2016	2017	2018
Oral Diazepam Equivalent	984,731	1,060,891	1,306,646	1,297,761	1,221,778

Appendix G: Coroner Report – Opioid Related Deaths

Saskatchewan Coroners Service

DRUG TOXICITY DEATHS
Saskatchewan, 2010 to 2018
(Updated – January 9, 2019)

The data in the following tables include all death investigations concluded by the Saskatchewan Coroners Service (SCS) **between January 1, 2010 and December 31, 2018** where the cause of death was due to a **Drug Toxicity (Single or Combined Drug Toxicity)**. The statistics shown are subject to change as new investigations are undertaken and/or on-going investigations are concluded.

For the following tables please note:

- "Undetermined" indicates that after completing an investigation, there is equal evidence, or a significant contest between one or more classifications.
- The statistics for 2016, 2017 and 2018 are preliminary given that not all death investigations for these years have been concluded.

Drug Toxicity Deaths by Manner of Death, 2010 – 2018

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Accident	52	56	60	62	67	91	92	91	70
Suicide	21	24	17	21	13	23	13	16	16
Homicide	--	--	--	--	--	--	--	--	--
Undetermined	5	6	9	5	5	7	4	7	1
Total	78	86	86	88	85	121	109	114	87

Breakdown of Opioid Drugs Identified in Drug Toxicity Deaths by Manner of Death, 2010 – 2018

		Codeine	Fentanyl	Heroin	Hydrocodone	Hydromorphone	Methadone	Morphine	Oxycodone	Opioid (Unknown)	W-18*	Carfentanyl
2010	Accident	4	2	--	--	12	31	12	10	--	--	--
	Suicide	2	--	--	--	2	--	3	--	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	--	--	--	--	--	3	1	1	--	--	--

Source: Saskatchewan Coroners Service 1 Updated: January 9, 2019

Breakdown of Opioid Drugs Identified in Drug Toxicity Deaths by Manner of Death, 2010 – 2018

		Codeine	Fentanyl	Heroin	Hydrocodone	Hydromorphone	Methadone	Morphine	Oxycodone	Opioid (Unknown)	W-18*	Carfentanyl
2011	Accident	7	1	--	--	18	20	12	5	--	--	--
	Suicide	2	--	--	--	1	3	3	4	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	--	1	--	--	3	1	--		--	--	--
2012	Accident	12	6	1	--	16	14	19	3	--	--	--
	Suicide	4	--	--	--	1	1	--	2	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	2	1	--	--	--	2	2	2	--	--	--
2013	Accident	3	9	--	--	17	31	10	7	1	--	--
	Suicide	2	1	--	--	4	2	4	1	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	--	--	--	--	2	2	--	1	--	--	--
2014	Accident	5	9	--	--	22	30	15	4	--	--	--
	Suicide	--	2	--	--	1	4	2	1	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	--	--	--	--	1	--	1	2	--	--	--
2015	Accident	10	21	--	--	30	37	21	3	--	1*	--
	Suicide	1	1	--	--	4	2	3	2	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	1	--	--	--	3	--	2	--	--	--	--
2016	Accident	8	8	1	--	26	34	10	4	--	--	--
	Suicide	1	--	--	--	1	2	--	--	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	1	1	--	--	1	1	--	--	--	--	--
2017	Accident	13	14*	--	5	27	20	24	3	--	--	3
	Suicide	3	--	--	1	7	1	2	--	--	--	--
	Homicide	--	--	--	--	--	--	--	--	--	--	--
	Undetermined	--	1	--	--	1	1	1	1	--	--	--

Source: Saskatchewan Coroners Service 2 Updated: January 9, 2019

Appendix H: Budget and Actuals

(see attached)

Appendix I: Audited Financial Statements 2017

(see attached)

Appendix J: Educational Letter (sample)

REGISTRAR
KAREN SHAW, M.D.

College of Physicians and Surgeons of Saskatchewan

101 -2174 Airport Drive
SASKATOON, SK S7L 6M6

Business: (306) 244-7355
Fax: General (306) 244-0090

May 3, 2018

No Response Required

PERSONAL AND CONFIDENTIAL

Dr. John Doe
Box 1212
Any Town, SK S0S 0S0

RE:

Jane Brown
HSN: 101 101 101
(non-NIHB beneficiary)

Dear Dr. Doe,

Enclosed please find the computer printout of the prescribing of Prescription Review Program (PRP) medications, which includes a prescription stimulant, to the above-named patients.

Methylphenidate is one of the top three most commonly misused medications encountered by the PRP in Saskatchewan, along with hydromorphone and gabapentin. Additionally, in adulthood, substance use disorders are commonly seen concomitantly with Attention Deficit Hyperactivity Disorder (ADHD). [CADDRA 2018, p.20] Due to the prevalence of prescription stimulant misuse, the PRP wishes to provide support and education related to the prescribing for these patients. Be aware, that this information is merely made available to you to assist you in improving the health outcomes related to the management of ADHD and is not intended to accuse you or your patient of any impropriety.

Please be aware the Canadian ADHD Resource Alliance (CADDRA) *Canadian ADHD Practice Guidelines – Fourth Edition* were updated in 2018. To enhance the quality and appropriateness of care, the College of Physicians and Surgeons of Saskatchewan supports the use of these guidelines and recommends that a *CADDRA ADHD Assessment* be performed and documented for all patients diagnosed with ADHD. The Guidelines, along with a toolkit that contains resources such as assessment forms, treatment forms, and templates, may be downloaded from the website for free at www.caddra.ca. For your ease of reference, we have enclosed some excerpts that you may find useful related to the management of ADHD in adults.

Along with the decision to utilize medication as part of the treatment plan, ensure you have collaborated with your patients to establish and document the symptomatic and functional goals of therapy. Take note that long-acting psychostimulants are recommended by the Guidelines as first-line treatment agents. Beyond the compliance benefits, long-acting stimulants may lower the risk of diversion and tend to be better tolerated than immediate-release formulations. While both the methylphenidate and amphetamine classes are considered equal in terms of efficacy and tolerability, patients may respond more favourably to one over the other. A trial of the long-acting formulation of each class is recommended before moving into the second-line therapies, such as atomoxetine or immediate-release psychostimulants.

Furthermore, if you have not already done so it is recommended that you establish a written treatment agreement with your patients which outlines the boundaries regarding refills, not selling or giving any of the medication away, taking the medication as directed, and providing random urine screens as requested. The monitoring of random urine screens at least once annually is recommended for all patients being chronically prescribed Prescription Review Program medications. With this approach you are not singling out or accusing your patients of inappropriate use of Prescription Review Program medications, but you are ensuring that you are receiving all the objective information needed to make rational prescribing decisions.

If your patient is eligible for medication coverage through the **Non-Insured Health Benefits (NIHB)** Program:

Currently, NIHB does not pay for brand name Ritalin, however NIHB will cover the full cost of generic brand methylphenidate, as well as Concerta, to a maximum total daily stimulant dose of 150 mg. Any patient requests for a brand name preparation (particularly one that is not covered by the drug plan), when a generic version is available may be an indication of possible drug misuse or diversion. In order to reduce the potential for misuse or diversion of brand name products, you may wish to consider indicating “generic – no substitution” on your prescriptions for methylphenidate preparations, the exception being for long-acting preparations for which no generic is currently available on formulary in Saskatchewan.

If your patient is not eligible for medication coverage through the Non-Insured Health Benefits (NIHB) Program, but covered by the **provincial drug plan or private insurers**:

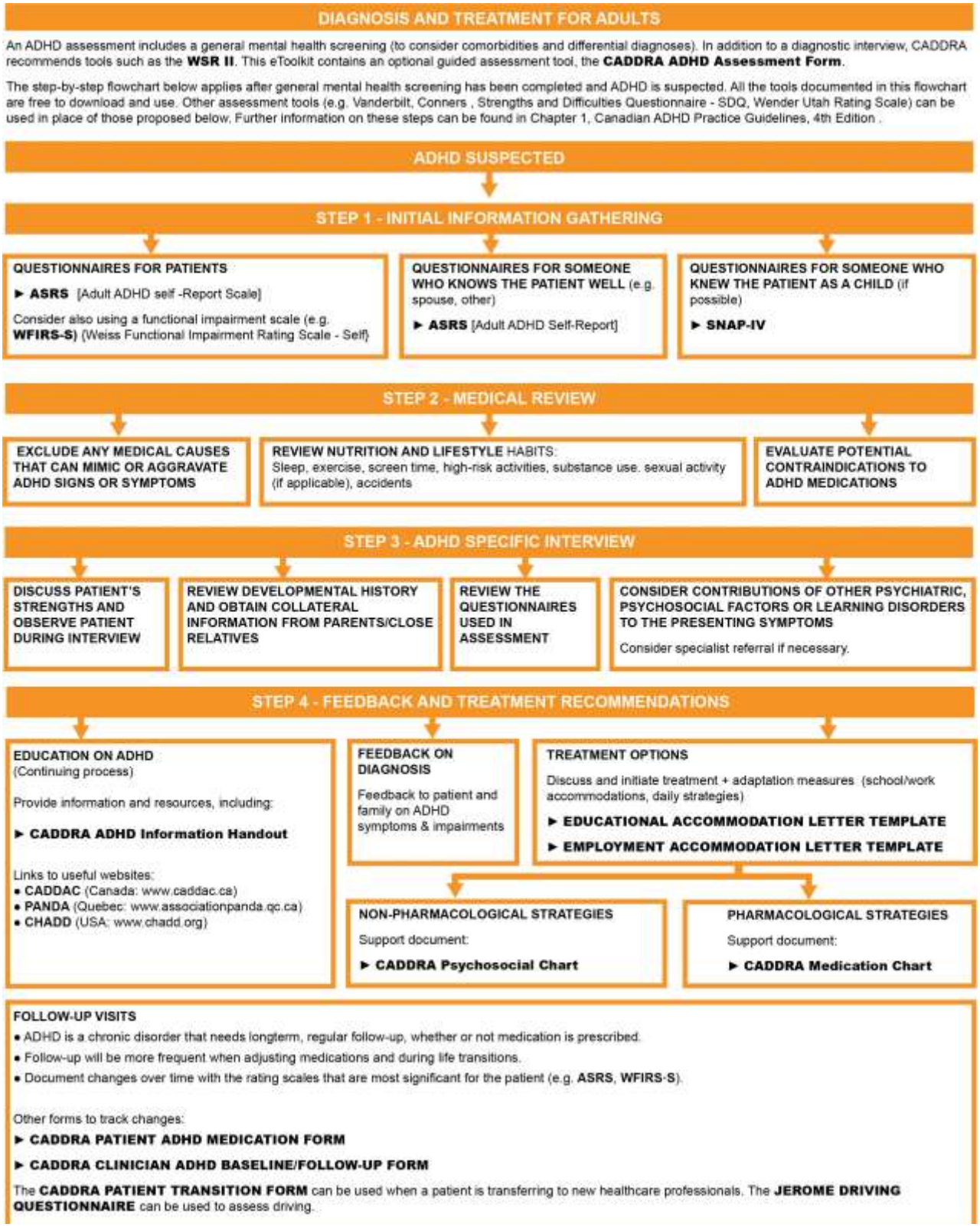
Any patient requests for a brand name preparation when a generic version is available may be an indication of possible drug misuse or diversion. In order to reduce the potential for misuse or diversion of brand name products, you may wish to consider indicating “generic – no substitution” on your prescriptions for methylphenidate preparations, the exception being for long-acting preparations for which no generic is currently available on formulary in Saskatchewan.

I hope you find this information valuable. A reply is not required at this time as this letter is meant to alert you to the use of either brand name Ritalin, high-dose stimulants or regular early refills by your patient, as well as to provide you with some valuable tools and resources related to the management of ADHD.

Sincerely,

Julia Bareham BSP, MSc
Pharmacist Manager, Prescription Review Program
Phone: 306-244-7355
e-mail: prp@cps.sk.ca

Flowchart 1.5 - Diagnosis and Treatment – Adult[1]



1. Excerpt from: Canadian ADHD Resource Alliance (CADDRA): Canadian ADHD Practice Guidelines, Fourth Edition, Toronto ON; CADDRA, 2018, page 13.

Table 5.13 – Medical Treatment for ADHD – Adults (18+)[2]

Brand Name	Active Ingredient	Dosage Form	Starting Dose[1]	Titration Schedule Every 7 Days		Total Maximum Daily Dose	
				Product Monograph	CADDRA[2]	Product Monograph	CADDRA[2]
FIRST LINE AGENTS – Long-acting psychostimulants							
Adderall XR®[3]	amphetamine mixed salts	5, 10, 15, 20, 25, 30 mg cap	10 mg q.d. a.m.	↑ 10 mg	↑ 5 mg	20-30 mg	50 mg
Biphentin®	methylphenidate	10, 15, 20, 30, 40, 50, 60, 80 mg cap	10-20 mg q.d. a.m.	↑ 10 mg	↑ 5-10 mg	80 mg	80 mg
Concerta®[3]	methylphenidate	18, 27, 36, 54 mg tab	18 mg q.d. a.m.	↑ 18 mg	↑ 9-18 mg	72 mg	108 mg
Vyvanse®	lisdexamfetamine	10, 20, 30, 40, 50, 60, 70 mg cap	20-30 mg q.d. a.m.	By clinical discretion	↑ 10 mg	60 mg	70 mg
SECOND LINE / ADJUNCTIVE AGENTS - Short-acting and intermediate-acting psychostimulants ***Indications for use: a) p.r.n. for certain activities; b) to augment[5] long-acting formulations early or late in the day, or early in the evening and c) when long-acting agents are cost prohibitive***							
Dexedrine®[3]	dextro-amphetamine	5 mg tab	2.5-5 mg b.i.d.[6]	↑ 5 mg	↑ 2.5-5 mg	40 mg	50 mg
Dexedrine® Spansule®[7]	dextro-amphetamine	10, 15 mg cap	10 mg q.d. a.m.	↑ 5 mg	↑ 2.5-5 mg	40 mg	50 mg
Ritalin®[3]	methylphenidate	10, 20 mg tab (5 mg generic only)	5 mg b.i.d. to t.i.d.[6] consider q.i.d	↑ 5-10 mg	↑ 5 mg	60 mg	100 mg
Ritalin® SR[8,3]	methylphenidate	20 mg tab	20 mg q.d. a.m.	↑ 20 mg (add q2pm dose)		60 mg	100 mg
SECOND LINE / ADJUNCTIVE AGENT - Long-acting non-psychostimulant - Selective norepinephrine reuptake inhibitor **Indications for use: Monotherapy (off-label: prescribed as an adjunctive therapy)**							
Strattera®	atomoxetine	10, 18, 25, 40, 60, 80, 100 mg cap	40 mg q.d.[4]	Adjust dosage every 7-14 days; to 60 then 80 mg/ day[9]		Lesser of 1.4 mg/kg/day or 100 mg/day	

p.r.n. = as needed

[1] CADDRA generally recommends starting at the lowest dose available
[2] A consensus decision has been made based on clinical use and research data. Doses per CADDRA that are over or under product monograph maximum or minimum doses should be considered off-label use
[3] Generic available. The Canadian ADHD Practice Guidelines' committee reported loss of symptom control in some patients when switched from original to generic drugs. Therefore long-acting psychostimulant generics are considered second line agents
[4] Vyvanse® 70mg is an off-label dosage for ADHD treatment in Canada
[5] To augment Adderall XR® or Vyvanse®, short-acting and intermediate-acting dextro-amphetamine products can be used. To augment Biphentin® or Concerta® short-acting methylphenidate products can be used
[6] b.i.d. refers to qam and qnoon and t.i.d. refers to qa.m., qnoon and q4p.m.
[7] Dexedrine® Spansule may last 6-8 hours
[8] Ritalin® SR may help cover the noon period but clinical experience suggests an effect similar to short-acting preparations
[9] Some adults may better tolerate a lower starting dose of 25 mg
[10] This Strattera® titration schedule applies to children and adolescents > 70 kg of body weight, and adults
Note: These tables summarize key information and cannot be considered exhaustive. Physicians should refer to Product Monographs for complete prescribing information.

[2] Excerpt from: Canadian ADHD Resource Alliance (CADDRA): Canadian ADHD Practice Guidelines, Fourth Edition, Toronto ON; CADDRA, 2018, page 79.

The **CADDRA eToolkit** contains forms that may be completed electronically and may be found at https://www.caddra.ca/etoolkit-forms/.

Forms you may be interested in incorporating into your practice include[2]:**Adult ADHD Self Report Scale (ASRS) -** The Symptom Checklist is an instrument consisting of the 18 DSM-IV-TR criteria. Six of the 18 questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS-V1.1 screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining 12 questions.

1. **Weiss Symptom Record II (WSR II)** - The WSR-II is a clinical tool that facilitates efficient collection of information about symptoms. The scale is written to be age and gender neutral so that it can be used as an adult self-report, an adolescent self-report, or a teacher report or parent report on a child. This allows gathering of information across different settings and direct comparison across informants, some of whom may not be present at the interview. The measure covers the diagnostic groupings of DSM-5 and a quick visual review of the completed scale allows the clinician to identify relevant symptom clusters that require more extensive follow up in the mental status. The scale is one of very few screeners that allows clinicians treating adults to pick up childhood onset disorders, and early onset adult disorders in children with the option of comparison of reports from multiple informants. The scale also can be given both to adolescents and adults as a self-report, teachers, parents and spouses.

   Use of the screener also assures that important items such as suicidal thoughts, obsessions, drug use etc. do not get missed because they were not expected. The scale is quick to complete and very easy to score in that a quick visual scan will identify those diagnostic clusters that are at risk.

2. **Weiss Functional Impairment Rating Scale – Self (WFIRS-S)** - The Weiss Functional Impairment Rating Scale (WFIRS) is a measure designed to assess the impact of ADHD or emotional and behavior problems on functioning. There are two versions of the scale. The self-report version is used by adolescents or adults to report on the domains of family, school and/or work, social, life skills, self-concept, and risky activities. The scale takes about 5 minutes to complete. Each item is rated from 0 (not a problem), 1 (somewhat), 2 (pretty much) or 3 (very much) based on the extent to which emotional or behavior problems have impacted functioning over the last month. A domain is considered impaired if two items are rated 2 or 1 item is rated 3. Items that are not relevant to an individual are scored 'not applicable' and not included when computing a mean score. The scale is user friendly for clinicians in that a quick glance allows the clinician to identify those areas that are significantly impaired both before and after treatment, and to compare this with the clinical interview. The WFIRS does not have any items redundant with ADHD symptoms, which makes it possible to look at symptoms and functioning as independent outcomes.
3. **CADDRA Clinician ADHD Baseline/Follow-Up Form**

[2] Excerpts from: Canadian ADHD Resource Alliance (CADDRA): CADDRA Toolkit PRINT Version from the Canadian ADHD Practice Guidelines, Fourth Edition, Toronto ON; CADDRA, 2018.