

Expanding Opioid Stewardship: Collaboration between Hospital and Primary Care Pharmacists

Joycelyn Lac, Carmen Leung, Karen Yan, Anita I Kapanen, and Tiana Tilli

To cite: Lac J, Leung C, Yan K, Kapanen AI, Tilli T. Expanding opioid stewardship: collaboration between hospital and primary care pharmacists. *Can J Hosp Pharm.* 2025;78(2):e3664. doi: 10.4212/cjhp.3664

INTRODUCTION

Between April 2015 and March 2016, one-third of hospital visits for opioid toxicity in British Columbia were for patients with an active opioid prescription at the time of overdose.¹ To help reduce opioid-related harms while increasing effective pain management, pharmacist-led opioid stewardship programs have been developed.² Pharmacist interventions within these programs include therapy adjustments, medication reviews, and academic detailing.³ In hospital and primary care settings, opioid stewardship interventions by pharmacists have led to reductions in both mean daily opioid doses and adverse events, as well as improvements in pain control and quality of life.⁴⁻⁸ Patients and prescribers have reported high rates of appreciation and satisfaction with these interventions.^{9,10}

Although opioid stewardship interventions within individual care settings have been effective, patient journeys span multiple care settings. A growing number of patients within the Canadian health care system are being cared for by primary care teams that include pharmacists.^{11,12} Collaboration between hospital and primary care pharmacists could provide ongoing opioid stewardship support through transitions of care, a period associated with increases in adverse events and medication errors.^{13,14} The literature has shown that intraprofessional collaboration between hospital and community pharmacists, as well as pharmacist-led transitions of care, can reduce hospital readmission rates across various conditions.^{15,16} Furthermore, analgesic titrations take time to complete, often extending beyond a patient's hospital stay.¹⁷ Primary care pharmacists could support completion of hospital-initiated interventions.

This study piloted an intraprofessional opioid stewardship collaboration between hospital and primary care pharmacists for patients who had pain and/or were taking opioids and who transitioned across care settings.

DESCRIPTION OF PRACTICE

Setting

A hospital opioid stewardship program was first established at Royal Columbian Hospital in New Westminster, British Columbia (2018), followed by programs at Surrey Memorial Hospital in Surrey (2019) and St. Paul's Hospital in Vancouver (2020).^{2,10,18} An intraprofessional collaboration, as described in this article, was subsequently established in 2021, involving 4 opioid stewardship pharmacists across these tertiary care hospitals and 5 pharmacists at a primary care clinic at the University of British Columbia's Faculty of Pharmaceutical Sciences. This clinic provides comprehensive medication management through an appointment-based model.

Patient Population

Hospitalized patients were identified for opioid stewardship consultations through referrals from the health care team and/or computer-generated reports identifying patients with high-risk opioid orders (where "high risk" was defined in relation to either the patient or the prescription), based on site-specific protocols.² Patients were triaged according to the number of high-risk opioid orders and a review of the electronic health record to identify those who might benefit from a full clinical assessment by an opioid stewardship pharmacist.² Patients followed by acute or complex pain services, palliative care teams, or the addictions medicine service (because of an opioid use disorder) were ineligible.² At one of the sites, patients admitted to critical care units were also ineligible.²

Patients seen by an opioid stewardship pharmacist during the hospital stay were eligible for referral to the primary care clinic at discharge if they were 18 years or older, were taking one or more opioids or were experiencing pain, had a community prescriber, and provided consent for the referral.

Study Design

A retrospective chart review was undertaken for patients referred to the primary care clinic between November 1, 2021, and April 19, 2023. Patients seen at the clinic were identified through a query of its electronic medical records system (OSCAR-EMR). Deidentified data were collected from the date of the patient's initial appointment at the clinic (baseline) until the end of 3 months of follow-up or the end of the overall study period, whichever came first. The study protocol was approved by the University of British Columbia Clinical Research Ethics Board (#H23-01255), which waived the need for informed consent for data collection, and the study was conducted in accordance with ethics principles set forth by the Helsinki Declaration.

Intervention

The opioid stewardship pharmacists reviewed health records, consulted with patients and health care teams, performed clinical assessments, and developed pain management recommendations. Before hospital discharge, they discussed a referral to the clinic with eligible patients, who received a handout (Appendix 1A) explaining the collaboration. For those who consented, a referral form (Appendix 1B), one or more opioid stewardship consult notes, and the hospital discharge summary were faxed to the primary care clinic. The opioid stewardship pharmacists and clinic pharmacists connected by phone if further case discussion was needed. Clinic staff contacted patients to schedule an initial 60-minute appointment, held in person or virtually, and 30- to 60-minute follow-up appointments as required. Clinic pharmacists assessed continuation of pain care plans and made recommendations to prescribers. Opioid stewardship pharmacists were copied on consult notes from initial appointments, for purposes of continuity, given that clinic pharmacists could not upload their notes to the provincial electronic health system. Pain medication recommendations made by the opioid stewardship pharmacists and the clinic pharmacists were patient-specific and aligned with Canadian guidelines for opioid use in chronic noncancer pain,¹⁹ as well as, when available, local or international practice standards for management of various pain syndromes. Initially, a single opioid stewardship pharmacist sent referrals to 1 of 2 designated clinic pharmacists (T.T.). As the program expanded, the opioid stewardship pharmacists, the 2 designated clinic pharmacists, and the clinic medical office assistant met every 1–2 months to discuss the appropriateness of referrals, to address logistics, to develop operational supports (Appendix 1), and to plan expansion of the referral process to all opioid stewardship and clinic pharmacists. After 6 months, all pharmacists in both settings were involved in patient referrals through this collaboration.

Outcomes

The outcomes of interest were patient characteristics, the status of hospital-initiated pain management care plans at

the time of each patient's initial clinic appointment, and pain management-related drug therapy problems identified and subsequent recommendations made by primary care pharmacists to address them.

Data Analysis

Two pharmacy student research assistants extracted the data, including primary care pharmacist notes and relevant documents, from patients' charts (e.g., opioid stewardship faxes, medication lists from PharmaNet [the provincial data system]). Daily opioid use was charted on the basis of patient reports during appointments. Qualitative variables were reported as percentages and quantitative variables as means with standard deviations. Microsoft Excel spreadsheet software (version 16.82) was used for the analyses.

EVALUATION OF PROGRAM

Patient Characteristics

Forty-two patients were referred to the primary care clinic as part of the opioid stewardship collaboration during the study period, of whom 22 were included in this analysis (Table 1). The others declined the service when called

TABLE 1. Baseline Characteristics of Patients Seen by Opioid Stewardship Pharmacist in Hospital, then Referred to and Seen by Pharmacist at Primary Care Clinic

Characteristic	No. (%) of Patients ^a (n = 22)
Age (years) (mean ± SD)	56.7 ± 15.8
Sex, female	11 (50)
Psychiatric condition	15 (68)
Substance use disorder	8 (36)
Type of pain leading to clinic referral	
Mixed	8 (36)
Nociceptive	7 (32)
Neuropathic	6 (27)
Other	1 (5)
Duration of pain leading to clinic referral	
< 3 months	16 (73)
3–12 months	0 (0)
> 12 months	6 (27)
Use of non-opioid analgesic at baseline	
Gabapentinoid	17 (77)
Acetaminophen	17 (77)
Serotonin-norepinephrine reuptake inhibitor	13 (59)
Nonsteroidal anti-inflammatory drug	7 (32)
Tricyclic antidepressant	6 (27)
Cannabis ^b	6 (27)

SD = standard deviation.

^aExcept where indicated otherwise.

^b"Cannabis" encompasses all varieties and forms of cannabis, including nabilone, tetrahydrocannabinol, and cannabidiol.

to schedule their initial clinic appointment ($n = 9$), were unable to be reached by the clinic ($n = 8$), were seen outside the study period ($n < 5$), or were rehospitalized before they could be seen at the clinic ($n < 5$). The average time from the date of referral to the first clinic appointment was 16.7 days, with an average of 2.9 appointments per patient over 3 months. The top reasons for referral were opioid tapering ($n = 19$, 86%), optimization of non-opioid analgesic ($n = 10$, 45%), and medication review ($n = 6$, 27%).

The mean total daily dose of opioids was 49.4 mg morphine equivalent at baseline and 41.6 mg morphine equivalent at follow-up. Seventeen patients (77%) were taking opioids (including over-the-counter codeine) at their initial clinic appointment, whereas 12 (55%) patients were known to be doing so by the 3-month follow-up. The 5 patients who discontinued opioid therapy had all been referred for acute pain (i.e., lasting less than 3 months).

Interventions by Hospital Pharmacists

Opioid stewardship pharmacists made a total of 122 medication recommendations (mean 5.5 per patient, standard deviation [SD] 2.1), as recorded in their pain management consult notes. The mean proportion of recommendations implemented per patient at the initial clinic appointment was 74%. Of the 34 recommendations not in place at the initial clinic appointment, reasons included persistent pain ($n = 9$, 26%), patient preference ($n = 6$, 18%), lack of patient understanding ($n = 4$, 12%), supply issues ($n = 4$, 12%), cost barriers ($n = 3$, 9%), and adverse effects ($n = 2$, 6%). For the remaining 18% ($n = 6$) of recommendations not implemented at the initial appointment, the reason was unknown because of unclear documentation regarding whether or not the recommendation had been implemented (or implemented and then discontinued by the time of the initial clinic appointment).

Interventions by Primary Care Pharmacists

Clinic pharmacists addressed a total of 89 drug therapy problems with 114 recommendations across all patients within their first 3 months of appointments (Table 2). Multiple recommendations may have constituted the plan to address a single drug therapy problem (mean 1.3 recommendations per plan, SD 1.7). For the 62 drug therapy problems with known outcomes, plans were implemented for 43 (69%); for the remaining 19 problems with known outcomes, the plans were not implemented for patient-related reasons ($n = 14$, 23%) or prescriber-related reasons ($n = 5$, 8%).

IMPLICATIONS AND SIGNIFICANCE

An opioid stewardship collaboration between hospital and primary care pharmacists was successfully piloted. This project helped to promote communication by establishing 2-way access to consult notes and facilitating case

discussions by telephone. Addressing logistical challenges during collaboration team meetings led to the development of operational supports, including a patient information handout (Appendix 1A). This handout explained the collaboration, with the aim of promoting informed decision-making by the patient during referrals and serving as a reference once the patient was home. A collaboration-specific notice of appointment was also developed, to inform community prescribers about the clinic's services and to clarify role expectations, especially with regard to prescribing pain medications (Appendix 1C). Overall, the findings from this evaluation suggest that intraprofessional pharmacist collaboration can improve the implementation and continuity of pain care plans.

More specifically, this retrospective evaluation showed that collaboration between hospital and primary care pharmacists led to refinement of hospital-initiated pain care plans according to patients' changing needs as they transitioned home. Although the opioid stewardship pharmacists individualized their recommendations, pain care plans were often not fully in place at the time of initial primary care appointments. Reasons included persistent pain, patient-related factors (e.g., preferences, understanding), and medication access issues (e.g., supply challenges, cost barriers) in the home environment. Persistent pain may arise from changing pain needs after discharge, as analgesic requirements may increase as other supports are reduced.²⁰ Additionally, it may be necessary to reduce tapering rates as the total daily opioid dose is decreased.¹⁷ Furthermore, opioid-sparing analgesics often require weeks of titration to achieve therapeutic doses and thus may be found to be

TABLE 2. Drug Therapy Problems Identified and Recommendations Made by Primary Care Pharmacists for Patients Referred by Opioid Stewardship Pharmacists Practising in Hospital

Problem or Intervention	No. (%)
Drug therapy problem identified	$n = 89$
Adverse drug reaction	19 (21)
Dose too low	18 (20)
Unnecessary drug therapy	13 (15)
Needs additional drug therapy	11 (12)
Different drug needed	11 (12)
Dose too high	9 (10)
Noncompliance	8 (9)
Pharmacist recommendation to address therapy problem(s)	$n = 114$
Stop medication	34 (30)
Start medication	29 (25)
Increase medication dose	19 (17)
Decrease medication dose	18 (16)
Eliminate patient-related barrier	8 (7)
Nondrug measure or referral	6 (5)

ineffective or intolerable when assessed at follow-up. The primary care pharmacists' recommendations completed the hospital pharmacists' pain care plans by promoting patient-specific refinements over time (Table 2).

These findings support calls for pharmacist-led transitions-of-care services in primary care.^{16,21} Similar pain management collaborations could focus on individuals with acute pain, given that the primary care pharmacists in this pilot successfully supported opioid discontinuation in this population. Collaborations of this type present an opportunity to prevent long-term opioid use, given that the risk increases with each day that opioids are supplied to opioid-naïve adults.²² Future collaborations might also benefit from including community pharmacists in the intraprofessional pain management team.

The strengths of this study included the participation of all pharmacists within the opioid stewardship program and at the primary care clinic, which enhanced generalizability. The limitations included the small sample size, the unknown rate of patient consent for initial referrals, and the high proportion of patients who consented but did not attend their initial appointment. The last of these limitations aligns with findings reported by Heaton and others,¹⁵ who noted that less than 30% of patients attended their pharmacist appointments after discharge. Additional limitations included the high numbers of unknown outcomes for recommendations made by hospital and primary care pharmacists. Future evaluations could benefit from prospective methodology with standardized documentation in primary care clinics to record the outcomes of interest and to ensure complete follow-up periods for all participants.

CONCLUSION

Opioid stewardship interventions should be expanded beyond individual care settings to include intraprofessional collaborations between hospital and primary care pharmacists.

References

1. Gomes T, Khuu W, Craiovan D, Martins D, Hunt J, Lee K, et al. Comparing the contribution of prescribed opioids to opioid-related hospitalizations across Canada: a multi-jurisdictional cross-sectional study. *Drug Alcohol Depend.* 2018;191:86-90.
2. *St. Paul's Hospital opioid stewardship program: 2 year program report January – December 2021.* British Columbia Centre on Substance Use and Providence Health Care; 2022 Jul [cited 2024 Feb 21]. Available from: <https://www.bccsu.ca/wp-content/uploads/2022/08/OSP-Y2-Report-Jul-2022.pdf>
3. Gondora N, Versteeg SG, Carter C, Bishop LD, Sproule B, Turcotte D, et al. The role of pharmacists in opioid stewardship: a scoping review. *Res Social Adm Pharm.* 2022;18(5):271447.
4. Bhimiji H, Landry E, Jorgenson D. Impact of pharmacist-led medication assessments on opioid utilization. *Can Pharm J (Ott).* 2020;153(3):148-52.
5. Tilli T, Hunchuck J, Dewhurst N, Kiran T. Opioid stewardship: implementing a proactive, pharmacist-led intervention for patients coprescribed opioids and benzodiazepines at an urban academic primary care centre. *BMJ Open Qual.* 2020;9(2):e000635.
6. Perry K, Ferron S, Norquist N, Mullen DM. A pharmacist-assisted initiative to improve chronic pain management and reduce opioid use in primary care. *Innov Pharm.* 2023;14(1):10.24926/iip.v14i1.5265.
7. Dole EJ, Murawski MM, Adolphe AB, Aragon FD, Hochstadt B. Provision of pain management by a pharmacist with prescribing authority. *Am J Health Syst Pharm.* 2007;64(1):85-90.
8. Chen J, Lu X, Wang W, Shen B, Ye Y, Jiang H, et al. Impact of a clinical pharmacist-led guidance team on cancer pain therapy in China: a prospective multicenter cohort study. *J Pain Symptom Manag.* 2014;48(4):500-9.
9. Coulson EE, Kral LA. The clinical pharmacist's role in perioperative surgical pain management. *J Pain Palliat Care Pharmacother.* 2020;34(3):120-6.
10. Ramasubbu C, Chernushkin K, Ng K, Legal M. Discerning clinician perceptions of an established opioid stewardship (DISCLOSE) program. *Can J Hosp Pharm.* 2023;76(1):63-70.
11. Rudoler D, Peckham A, Grudniewicz A, Marchildon G. Coordinating primary care services: a case of policy layering. *Health Policy.* 2019;123(2):215-21.
12. *Transforming our primary care system through primary care networks.* British Columbia Ministry of Health; 2019 Dec [cited 2024 Feb 23]. Available from: <https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/health-care-partners/health-newsletter/context-pcn-december-2019.pdf>
13. Thurston MM, Dupree LH, Shogbon Nwaesei A, Newsom LC. Incorporation of innovative strategies for patient education in pharmacist-led transition of care initiatives. *Ann Pharmacother.* 2024;58(6):657-60.
14. Kurteva S, Habib B, Moraga T, Tamblyn R. Incidence and variables associated with inconsistencies in opioid prescribing at hospital discharge and its associated adverse drug outcomes. *Value Health.* 2021;24(2):147-57.
15. Heaton PC, Frede S, Kordahi A, Lowery L, Moorhead B, Kirby J, et al. Improving care transitions through medication therapy management: a community partnership to reduce readmissions in multiple health-systems. *J Am Pharm Assoc.* 2019;59(3):319-28.
16. Slazak E, Cardinal C, Will S, Clark CM, Daly CJ, Jacobs DM. Pharmacist-led transitions-of-care services in primary care settings: opportunities, experiences, and challenges. *J Am Pharm Assoc.* (2003). 2020;60(3):443-9.
17. Wang Y, Wilson DL, Fernandes D, Adkins LE, Bantad A, Copacia C, et al. Deprescribing strategies for opioids and benzodiazepines with emphasis on concurrent use: a scoping review. *J Clin Med.* 2023;12(5):1788.
18. *St. Paul's Hospital opioid stewardship program: 6 month program report January – June 2020.* British Columbia Centre on Substance Use and Providence Health Care; 2020 Oct [cited 2024 Oct 16]. Available from: <https://www.bccsu.ca/wp-content/uploads/2020/10/OpioidStewardshipProgram-Final.pdf>
19. Busse JW, Craigie S, Juurlink DN, Buckley DN, Wang L, Couban RJ, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ.* 2017;189(18):E659-66.
20. Meints SM, Edwards RR. Evaluating psychosocial contributions to chronic pain outcomes. *Prog Neuropsychopharmacol Biol Psychiatry.* 2018;87(Pt B):168-82.
21. Ensing HT, Koster ES, Stuijt CCM, van Dooren AA, Bouvy ML. Bridging the gap between hospital and primary care: the pharmacist home visit. *Int J Clin Pharm.* 2015;37(3):4304.
22. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use - United States, 2006-2015. *MMWR Morb Mortal Wkly Rep.* 2017;66(10):265-9.

Joycelyn Lac, BMSc, is with the Faculty of Pharmaceutical Sciences, The University of British Columbia, Vancouver, British Columbia.

Carmen Leung, BSc, is with the Faculty of Pharmaceutical Sciences, The University of British Columbia, Vancouver, British Columbia.

Karen Yan, BSc(Pharm), is with the Faculty of Pharmaceutical Sciences, The University of British Columbia, Vancouver, British Columbia.

Anita I Kapanen, MSc, PhD, is with the Faculty of Pharmaceutical Sciences, The University of British Columbia, Vancouver, British Columbia.

Tiana Tilli, BSCh, PharmD, is with the Faculty of Pharmaceutical Sciences, The University of British Columbia, Vancouver, British Columbia.

Competing interests: None declared.

Address correspondence to:

Dr Tiana Tilli
Faculty of Pharmaceutical Sciences
University of British Columbia
2301–2405 Wesbrook Mall
Vancouver BC V6T 1Z3
email: tiana.tilli@ubc.ca

Funding: None received.

Acknowledgements: The authors thank the opioid stewardship hospital pharmacists for their collaboration, the primary care pharmacists for providing patient care during postdischarge appointments, and the medical office assistants in the various primary care clinics for their administrative support. We also recognize Isabella Durante who provided assistance with manuscript referencing.

Submitted: June 11, 2024

Accepted: November 11, 2024

Published: April 9, 2025

APPENDIX 1A. Collaboration-specific patient handout, developed to support the intraprofessional opioid stewardship collaboration between hospital and primary care pharmacists. © 2021 University of British Columbia. Reproduced by permission.

Insert hospital logo

Insert primary care clinic logo

**Pain Management After Hospital Discharge:
Support from the _____ (insert clinic name) _____ after Seeing a Hospital Pharmacist**

The _____ (insert clinic name) _____ will call you to book an appointment after hospital discharge.

The _____ (insert clinic name) _____ is working with hospital pharmacists to support people who have pain and/or are taking opioids. An appointment with the _____ (insert clinic name) _____ can be booked to review and monitor any medication changes or treatment plans started in hospital.

At the _____ (insert clinic name) _____, a team of pharmacists will work with you to make sure that the pain medications you take are effective and safe. This may involve seeing if a medication dose needs to be changed, other medications can be tried, or if a side effect needs to be managed. The pharmacists here do not write prescriptions or fill medications. They listen to your health concerns, help you solve medication problems and work with your family doctor, nurse practitioner, specialists and other pharmacists. There is no cost for your appointments with the _____ (insert clinic name) _____.

What you can expect at the _____ (insert clinic name) _____:

- **One-on-one appointments** that are personalized to your health needs.
- **Expert support** to solve medication problems that you might be having and to help you achieve your health goals.
- **Follow-up after hospital discharge** to help with any medication changes or treatment plans started in hospital.
- **Accessible care** with appointments available by phone, video or in-person.
- **Answers and information** about your medications.
- **The complete picture** of how all your medications are working for you – prescription, non-prescription, supplements and natural health products.

We look forward to helping with your pain management once you're back at home!

APPENDIX 1B. Opioid stewardship referral form, developed to support the intraprofessional opioid stewardship collaboration between hospital and primary care pharmacists. © 2021 University of British Columbia. Reproduced by permission.

Insert primary care clinic logo/contact info

Opioid Stewardship Referral Form

Services provided by *(insert clinic name)*

<p>Instructions</p> <ol style="list-style-type: none"> 1. Fill out as many fields below as possible 2. Attach relevant documents (e.g., consult notes) 3. Submit by: <ol style="list-style-type: none"> a. Fax: <i>(insert Fax number)</i> b. Secure e-mail: <i>(insert URL)</i> 4. Inform the patient that a referral was submitted 	<p>Next Steps</p> <ol style="list-style-type: none"> 1. Patient will be contacted directly to book their appointment 2. Patient will receive follow-up information by e-mail 3. Referring person will receive a notice of appointment once booked 				
<p>Urgency of Referral</p> <p><input type="checkbox"/> Urgent: see within 1-2 business days of discharge</p> <p><input type="checkbox"/> Non-Urgent: see within 1-2 weeks of discharge</p> <p><input type="checkbox"/> Routine: see within 1-2 months of discharge</p> <p>Discharge Date: _____</p>	<p>Name of Referring Provider</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Phone</td> <td style="width: 50%;">Fax</td> </tr> <tr> <td style="height: 30px;"></td> <td style="height: 30px;"></td> </tr> </table>	Phone	Fax		
Phone	Fax				

Patient Information

Legal Name*		Name Used	
Personal Health Number	Date of Birth (D/M/Y)	Gender*	Pronouns
Address (number, street, city, province, postal code)			
Phone		Email Address	
Community Pharmacy (name, location, phone)			

* Legal name and gender as stated on your BC Services Card is collected to access health records. We recognize that a person's name and gender can differ from what is on their government issued ID.

Reason(s) for Referral

Send a Copy of Consultation Report to...

Name	Phone	Fax

last update: 2024_04_29

APPENDIX 1C. Notice of appointment, developed to support the intraprofessional opioid stewardship collaboration between hospital and primary care pharmacists. © 2021 University of British Columbia. Reproduced by permission.

Insert primary care clinic logo/contact info

Notice of Appointment

Date	
To	
Fax Number	

This document contains patient personal information and is intended for the receiver only. If you have received this facsimile in error, please notify the sender immediately and destroy this document.

Patient Name	DOB (DD/MM/YYYY)	Personal Health Number
Appointment Date	Appointment Time	Patient Phone Number

Your patient was referred to the *(insert clinic name)* by the healthcare providers who cared for them during their recent hospital admission, for assistance with pain and/or opioid medication management following discharge. We will send you an appointment summary, including medication recommendations, but cannot prescribe.

This is to inform you that an appointment was:

- Booked:** This patient has been booked for the above appointment and has been notified. A consult note, with any updates and recommendations to consider, will be faxed to you after the patient is seen.
- Cancelled** **No-Showed** **Declined**

The Clinic attempted to contact the patient but was unable to schedule/conduct an appointment for the reason selected above. No further attempts will be made to contact this patient, but they are welcome to call the clinic should they be interested in our services in the future. Until then, the patient's pain and/or opioid medication management remains with their most responsible prescriber.

- Unable to be booked as we could not reach the patient despite multiple attempts**

Additional Comments

If you have further questions or concerns, please feel free to call us.