

PHARMACY OAMT REGISTRATION FORM

Pharmacies providing Opioid Agonist Maintenance Treatment services will notify the NSCP by completing and submitting this form. Information from this registry will be released to other health care providers to facilitate identifying pharmacies that could serve a patient, as required, in certain situations (i.e. OAMT patients moving into province etc.).

Date of Notification: mm / dd / yyyy

Pharmacy Trade Name:

Address:

Phone:

Email:

Fax:

Pharmacy Manager:

Please respond to the following questions:

- | | | |
|---|------------------------------|-----------------------------|
| 1. a) Is your pharmacy currently providing <i>methadone</i> dispensing? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| b) Is your pharmacy accepting new <i>methadone</i> patients? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| c) Is your pharmacy currently providing <i>buprenorphine/naloxone</i> dispensing? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| d) Is your pharmacy accepting new <i>buprenorphine/naloxone</i> patients? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. a) Is your pharmacy open 7 days a week, 365 days per year? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| b) If "no", please indicate which days the pharmacy is closed: _____ | | |

Note: Pharmacies not open 7 days a week must adjust their practices for patients who require daily witnessed ingestion on days when the pharmacy is not open. For further direction, refer to Standards 3, 5 and Appendix I.

Pharmacy managers are responsible to ensure that the provision of OAMT services by the pharmacy complies with the NSCP Standards of Practice including:

- Staff pharmacists have taken the necessary steps to satisfy the competency requirements for the provision of OAMT services as identified in the Standards of Practice.
- The pharmacy undertakes the expected activities associated with providing OAMT services, as identified in the Standards of Practice.

The pharmacy library includes the required references *Opioid Agonist Maintenance Treatment: A Pharmacist's guide to methadone and buprenorphine for opioid use disorder* (CAMH) and this document.

I hereby certify that the statements set out in this document are true and correct.

Dated at _____ this _____ day of _____, 20_____.

Pharmacy Manager Signature

Pharmacy Manager Name (please print)