Table 1. Recommendations Summary

Primary Care

- We **recommend** that management of opioid use disorder be performed in primary care* as part of the continuum of care for patients with opioid use disorder (strong recommendation, moderate quality evidence).

Diagnosis

- Clinicians **could consider** the use of a simple tool such as the Prescription Opioid Misuse Index (POMI) if assistance is needed identifying chronic pain patients who may have opioid use disorder (weak recommendation, very low quality evidence).

Pharmacotherapy

- We **recommend** clinicians discuss use of buprenorphine-naloxone or methadone with their patients for treatment of opioid use disorder (strong recommendation, moderate quality evidence).
    - Methadone may be superior for retention in treatment. However, buprenorphine-naloxone may be easier to implement in practice due to fewer prescribing restrictions and considerations.
- Clinicians **could consider** naltrexone for patients who have been opioid free for at least 7-10 days and who are unable or unwilling to use Opioid Agonist Therapy (weak recommendation, low quality evidence).
- We **recommend against** the use of cannabinoids for management of opioid use disorder (strong recommendation, very low quality evidence).

Prescribing Practices

- Clinicians **could consider** take-home doses (i.e. 2 to 7 days) as an option when need and stability indicate (weak recommendation, very low quality evidence).
- Clinicians **could consider** urine drug testing as part of the management of patients with opioid use disorder (weak recommendation, no RCT evidence).
- Clinicians **could consider** treatment agreements (i.e. contracts) in the management of opioid use disorder for some patients (weak recommendation, no RCT evidence).
- We **recommend against** punitive measures involving opioid agonist treatment (i.e. reduction in dose or loss of carries), unless safety is a concern (strong recommendation, moderate quality evidence).

Tapering

- We **recommend against** initiation of opioid agonist treatment with the intention to discontinue in the short-term. Opioid agonist treatment is intended as long-term management. Optimal duration is unknown and may be indefinite (strong recommendation, low quality evidence)

Psychosocial

- We **recommend** the addition of counselling to pharmacotherapy in patients with opioid use disorder where available (strong recommendation, low quality evidence).

Residential Treatment

- There is **insufficient evidence** to create a recommendation for or against the use of residential treatment for patients with opioid use disorder (no recommendation, no RCT evidence).

Comorbidities

- There is **insufficient evidence** to create specific recommendations for the following co-morbidities in patients with opioid use disorder: chronic pain, acute pain, insomnia, anxiety, ADHD (no recommendation, insufficient evidence).

*In RCTs, primary care may have included team-based care, support/training available, affiliation with substance misuse clinic, or 24-hour pager support. Training and supports will vary per practitioner, practice site and population served.