Appendix 2. Summary of GRADE Recommendations

Recommendation	Strength of Recommendation	GRADE rating of certainty of evidence	Reasons for Downgrading/Upgrading evidence
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	Moderate	Imprecision (-1)
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	Very Low	Imprecision (-1) Inconsistency (-1)
We recommend clinicians discuss use of buprenorphine-naloxone or methadone with their patients for treatment of opioid use disorder. 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.	Strong	Moderate	Buprenorphine: Risk of bias (-1) Methadone: Risk of bias (-1)
Clinicians could consider naltrexone for patients who have been opioid free for 7 to 10 days and are unable or unwilling to use Opioid Agonist Therapy.	Weak	Low	Risk of bias (-1) Indirectness (-1)
We recommend against the use of cannabinoids for management of opioid use disorder.	Strong	Very Low	Risk of bias (-1) Inconsistency (-1) Imprecision (-1)
Clinicians could consider take-home doses (i.e. 2 to 7 days) as an option when need and stability indicate.	Weak	Very Low	Risk of bias (-1) Indirectness (-1) Imprecision (-1)
Clinicians could consider urine drug testing as part of the management of patients with opioid use disorder.	Weak	No RCT evidence	Not Applicable

Recommendation	Strength of Recommendation	GRADE rating of certainty of evidence	Reasons for Downgrading/Upgrading evidence
Clinicians could consider treatment agreements (i.e. contracts) in the management of opioid use disorder for some patients.	Weak	No RCT Evidence	Not Applicable
We recommend against punitive measures involving opioid agonist treatment (i.e. reduction in dose or loss of carries), unless safety is a concern.	Strong	Moderate	Risk of bias (-1)
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	Low	Risk of bias (-1) Indirectness (-1)
We recommend the addition of counseling to pharmacotherapy in patients with opioid use disorder where available.	Strong	Low	Risk of bias (-1) Indirectness (-1)
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	Not applicable
There is insufficient evidence to create recommendations for the following co-morbidities in patients with opioid use disorder: • chronic pain • acute pain • insomnia • anxiety • ADHD	No recommendation	Insufficient evidence	Not Applicable

Note: GRADE = Grading of Recommendations Assessment, Development and Evaluation tool *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.