

## 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)<br>Inconsistency (-1)                                 |
| We recommend clinicians discuss use of buprenorphine-naloxone or methadone with their patients for treatment of opioid use disorder.<br>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:<br>Risk of bias (-1)<br>Methadone:<br>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)<br>Indirectness (-1)                                 |
| We recommend against the use of cannabinoids for management of opioid use disorder.  | Strong                     | Very Low                              | Risk of bias (-1)<br>Inconsistency (-1)<br>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)<br>Indirectness (-1)<br>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)<br>Indirectness (-1)     |
| We recommend the addition of counseling to pharmacotherapy in patients with opioid use disorder where available.  | Strong                     | Low                                   | Risk of bias (-1)<br>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: <ul style="list-style-type: none"> <li>• chronic pain</li> <li>• acute pain</li> <li>• insomnia</li> <li>• anxiety</li> <li>• ADHD</li> </ul> | 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.