

<p style="text-align: center;">Clinical Pearls</p> <ul style="list-style-type: none"> • Routinely ask about cannabis use in primary care (just like tobacco and alcohol), & monitor for cannabis use disorder. • After failure of ≥3 other drugs, a trial of prescription cannabinoids (rather than cannabis) may be reasonable for treating neuropathic pain.² • Approach cannabinoids with similar caution as opioids – see box below. • Start cannabinoids at a low dose, and gradually titrate. A few clinical trials suggest some efficacy even at very low doses.^{21,22} Adverse effects are common; monitor; stop or taper if not tolerated. • Inhaled cannabis is <u>not</u> a preferred route of administration due to difficulty dosing, risk of respiratory damage, and multi-component composition. • Cannabis is <u>not</u> recorded on PIP in Saskatchewan (Rx-cannabinoids are). • The potential harms of cannabis are often underappreciated by patients. Informed consent and patient education are advisable. The RxFiles Cannabis Patient Booklet may be a useful tool (available online 📖). 	<p style="text-align: center;">Definitions and Background Information</p> <p>Cannabinoid receptors: CB1 receptors (primarily in the central and peripheral nervous systems) and CB2 receptors (primarily in the immune system) are part of an endocannabinoid system in humans.¹</p> <p>Cannabinoids: compounds that activate cannabinoid receptors. Endogenous cannabinoids in humans include AEA & 2-AG. Two studied, although still poorly understood, cannabinoids are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).</p> <p>Cannabis: aka marijuana. Contains 400+ compounds, including 120+ cannabinoids. Often marketed based on THC & CBD concentrations, although it is uncertain if these are the most important compounds in cannabis.</p> <p>Prevalence (2018): <u>14%</u> of Canadian adults used cannabis in last 3mos, <u>6%</u> used daily, & <u>1%</u> were registered for medical use.^{16,30}</p> <p>Challenges with the evidence: <i>limited & small RCTs</i>, of short duration, studying differing routes, forms & types of cannabinoids results in low confidence in assessing benefits & harms. Trials with <i>longer duration</i> tend to show less benefit,¹¹ implying that if an effect exists, it may wear off over time. Further, few cannabinoid trials are <i>adequately blinded</i> due to the psychotropic effects of cannabinoids (~90% of patients can guess their allocation),¹¹ which is thought to bias results towards benefit.¹⁷</p> <p>Current (2018) legal status in Canada: Rx cannabinoids are Schedule II (controlled substances). Dried cannabis & oils are legal from a licensed producer with physician authorization, or from a cannabis retail store. Cannabis edibles aren't legal for purchase (yet).</p>
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<p style="text-align: center;">Do Cannabinoids Work (Medicinally)?</p> <p style="text-align: center;"><i>Note: See "Challenges with the evidence" comments, above</i></p> <p>Compared to placebo, cannabinoids <u>may</u> (limited, low quality evidence):</p> <ul style="list-style-type: none"> • ↓ chronic neuropathic pain NNT=11 for ≥30% reduction over ~4 wks.^{2,15} • ↓ chemotherapy-induced nausea & vomiting NNT=3 for control of nausea/vomiting over ~1 day.² • ↓ spasticity of multiple sclerosis or spinal cord injury NNT=10 for ≥30% ↓ spasticity over ~6wks.⁶⁸ • ↓ seizures in Lennox-Gastaut & Dravet syndrome with CBD NNT=4-7 for ≥50% reduction in seizure frequency over ~14 wks.² • ↓ cachexia in HIV/AIDS, cancer, palliative care: weak evidence. <p style="text-align: center;">Are Cannabinoids Safe?</p> <p>Adverse effects are very common with cannabinoids. Approximately 8-9 patients out of 10 will develop an adverse effect to cannabinoid therapy and ~1 patient in 10 will stop therapy because of an adverse effect.² Notable adverse effects include feeling “high” NNH=4; sedation NNH=5; speech disorders NNH=5; dizziness NNH=5; and ataxia/muscle twitching NNH=6.² Additional concerns include driving impairment, addiction risk, euphoria, and psychosis. Some cannabinoids may be safer than others, but this is generally unstudied (including specific THC/CBD ratios). See next page of this chart.</p>	<p>Differing Health Care Perspectives on Medical Cannabis</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="background-color: #d3d3d3;">Cannabis is useful?</th> <th style="background-color: #d3d3d3;">Cannabis should be avoided?</th> </tr> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> • <i>Some patients have tried a dozen or so standard medications without success, and now want to try cannabis. If these patients find success with cannabis, and we help them do so safely, we will have done a great service for them.</i> • <i>When patients say a medication helps, we should listen to them, just as we listen when patients tell us the antidepressant or anti-emetic we prescribed are helping.</i> • <i>By developing products with different THC-to-CBD ratios, perhaps tolerability concerns can be addressed.</i> • <i>If cannabis helps our patients use less opioids, that's an attractive tradeoff.</i> </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> • <i>Every other medication we prescribe has standard dosing and potency; no other medication is smoked. Inhaled cannabis contains 400+ compounds, and it's unclear which are important and how they interact. On top of that, each inhaled puff can be different from the last.</i> • <i>There is no evidence that cannabis is superior to prescription cannabinoids; therefore regulated & approved prescription cannabinoids should always be preferred.</i> • <i>In clinical trials, benefits are typically small and may just be a placebo effect. Meanwhile, adverse events are common. We have a professional duty to only prescribe medications when it can be done safely, and with cannabis the harms almost always outweigh the benefits. These harms may not be fully appreciated by patients.</i> • <i>If we routinely authorize cannabis today, will we mirror the opioid crisis tomorrow?</i> </td> </tr> </table> <p style="background-color: #d3d3d3; padding: 5px;">A final thought: <i>If a patient told you they were getting benefit from ibuprofen over-the-counter, you might recommend they continue taking it. You might even prescribe it. But would you feel the same way if the patient was using 6 grams of ibuprofen per day? Or if the patient insisted that the ibuprofen was improving their blood sugar control? Or if the patient had a history of GI bleeds?</i></p>	Cannabis is useful?	Cannabis should be avoided?	<ul style="list-style-type: none"> • <i>Some patients have tried a dozen or so standard medications without success, and now want to try cannabis. 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<p style="text-align: center;">Cannabinoids for pain, or Opioids ...</p> <p>Trial evidence comparing cannabinoids and opioids is limited.⁵⁷ But they do have some similarities and differences to consider:</p> <ul style="list-style-type: none"> • Efficacy: For both drug classes, RCT evidence is of low quality and short duration, and tends to show only a modest reduction in pain. Longer trials tend to show less benefit. However, despite the relative lack of quality evidence, patients often have strong beliefs about the value of each drug class. • Adverse effects: Nausea, sedation, and euphoria are adverse effects of both drug classes. Opioids can cause constipation;²⁵ cannabinoids can cause psychiatric disturbances (e.g. anxiety, agitation, amotivation, psychosis).²⁷ Adverse effects appear dose-related (↑dose = ↑AE). Both drug classes may be used by patients as an “escape”. • Addiction risk: With prescription opioids, estimated to be 5.5%.²⁵ With <i>non-medical</i> cannabis, estimated to be 9%.²⁶ (The risk with medical cannabinoids is unstudied.) • Fatal overdose risk: With prescription opioids, 0.23% with >100mg morphine per day (↑risk with ↑dose).²⁵ With cannabis, fatal overdose risk appears to be negligible.¹ • For both drug classes, the concept of a trial with an exit strategy is important. Not all patients will respond to these medications. 	<p style="text-align: center;">... Or Something Better?</p> <p>If patients are wanting an escape from pain – physical or emotional – there are better choices! Non-pharmacological approaches to coping and living well with pain will be essential for success!</p>
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Miscellaneous info: **Synthetic illicit cannabinoids:** e.g. K2, Spice – highly potent CB1/CB2 receptor agonists; case reports of severe acute toxicity.⁵² **Phytocannabinoid:** a cannabinoid derived from cannabis (e.g. THC, CBD, & others). **THC:** a partial CB1 & CB2 agonist. **CBD:** uncertain mechanism of action. **Entourage effect:** an unproven hypothesis that efficacy of cannabinoids is increased (or adverse effects decreased) when they are used in combination and/or in particular ratios and/or with flavonoids, terpenoids. **Topical cannabis** e.g. creams: an unproven dosage form, promoted as local analgesia without systemic effect, but currently without trials to support. **Concentrated Cannabis** e.g. hash, shatter, budder, wax: contains THC as high as 90%. **Dabbing:** vaping small amounts of concentrated marijuana. **Travelling with cannabis outside of Canada:** not recommended. **Non-medical cannabis:** aka “recreational”. **Is cannabis opioid-sparing?:** Evidence is still unclear.⁵⁸⁻⁶⁶

	Generic/TRADE	Indications & Comments	DOSING	\$/30d	Adverse Events AE / Contraindications CI / Drug Interactions DI / Monitor M
Prescription Cannabinoids (pharmaceutical grade)	Nabilone CESAMET, g THC analogue 0.5, 1mg cap ☹ ☹ ☹ 0.25mg cap ✗ ☹ ☹	Preferred over cannabis. ^{CFP¹⁸} ✓ severe nausea/vomiting from cancer chemotherapy ☹ off-label: AIDS-related anorexia ☹ Palliative pain ☹ Neuropathic pain • Not detected in SK urine drug screen	Initial: 0.25-0.5mg po HS Usual: 1-2mg po daily-BID for CINV 1mg BID for neuropathic pain Usual max: 6mg/day	\$22-18 g \$112-215 g \$112 g \$310 g ^{\$1200}	AE: Some notes on adverse effects: • percentages below are often “worst case scenarios” from systematic reviews, yet due to trial-design issues could also be underestimates. • adverse effects appear dose-related (↑dose = ↑AE) • it is difficult to compare AE rates between agents, due to few head-to-head trials. • THC appears to be the main component responsible for causing a “high” (low quality evidence). ⁴⁴ CBD possibly safer than THC, but some of its psychotropic effects are underappreciated (e.g. vs placebo in predominately pediatric trials: aggression/anger 3-5% vs <1%; irritability/agitation 5-9% vs 2%; somnolence 25% vs 8%). ³¹ drowsiness or sedation up to 50% across cannabinoids. ² dizziness up to 32% across cannabinoids. ² psychiatric disturbances up to 17% across cannabinoids, ² and up to 27% with inhaled cannabis. ^{COMPASS} including depression, anxiety, panic, paranoia, hallucination. euphoria up to 15%, and feeling “high” up to 35% across cannabinoids. ² acute psychosis or dissociation up to 5% across cannabinoids. ² speech disorders up to 32%, and ataxia up to 30% across cannabinoids. ² impaired memory up to 11% across cannabinoids. ² irritability or agitation up to 9%, and anger or aggression up to 5% with CBD. ³¹ appetite changes: decreased appetite in up to 22% of patients on CBD, ³¹ but conversely increased appetite in up to 38% of patients on dronabinol. ¹⁸ GI issues: dry mouth; diarrhea up to 20%, vomiting up to 15% with CBD. ^{19,31} Conversely ↓ nausea in up to 20% of pts with dronabinol. ¹⁸ SATIVEX: mouth irritation. pneumonia up to 8% with oral CBD. ³¹ ↑ LFTs up to 16% of pts on CBD; ³¹ related to concomitant valproate/clobazam. driving impairment: risk of fatal car crash approximately doubles with THC. ^{28,55} schizophrenia unmasking: cannabis may hasten first psychotic episode by 2-6yrs. ⁸ withdrawal with abrupt discontinuation (see withdrawal symptoms on next page) cannabis hyperemesis syndrome: severe abdominal pain/vomiting; requires drug discontinuation; relieved by hot shower; applying capsaicin to abdomen useful. ³² red eyes reported with non-medical use of oral and smoked THC. rare or uncertain: ?sexual problems, ?cancer testicular, ?↓BMD, ?pancreatitis. Harms specific to smoked cannabis: cough 7%, respiratory issues (e.g. development of COPD, pulmonary aspergillosis, ?lung cancer), ³⁵ cardiovascular issues (e.g. ↑HR, ¹ postural hypotension, ¹ ?↑MI 1 hour after smoking, ³⁹) ?steatosis with hepatitis C, ?gynecomastia, ?thrombophlebitis, contaminants in unregulated cannabis (e.g. lead, fentanyl, pesticides) CI: pregnancy; breastfeeding; age <21-25yrs (CBD exception: tx-resistant seizures?); psychosis or schizophrenia history. ⁶ Caution: in elderly, substance abuse history, driving (sometimes a contraindication) <4hrs after inhalation / <6hrs after ingestion / <8 hrs after euphoria (note: driving impairment studies have focused on THC component); history of seizures, psychiatric disorders (e.g. bipolar, anxiety), cardiovascular disease, or respiratory disease. ⁹ DI: A note on drug interactions: Interactions are not fully understood; many are theoretical. Cannabis has many compounds besides THC & CBD; these may have unknown drug interactions. Watch closely for pharmacodynamic (additive) interactions. All cannabinoids: additive CNS effects (e.g. sedation, confusion, impairment) with alcohol, anticholinergics, anti-epileptics, benzos, opioids, etc. THC-containing products 2C9 & 3A4 substrate: ↓ levels by CBZ, SJW, phenytoin, etc. ↑ levels by clarithromycin, fluoxetine, fluvoxamine, gemfibrozil, etc. CBD-containing products 2C19 & 3A4 substrate: ↓ levels by CBZ, SJW, phenytoin, etc. ↑ levels by clarithromycin, fluconazole, fluvoxamine, gemfibrozil, etc. 2C19 inhibitor: ↑ levels of citalopram, clobazam; ↓ levels of clobidogrel ?additive hepatotoxicity risk with valproic acid or clobazam. ^{19,20} Smoked cannabis: smoking may result in 1A2 induction; e.g. ↓ levels of antipsychotics, caffeine, TCAs, theophylline, warfarin Nabilone: while a THC-mimic, does not have THC drug interactions. M: HR, BP, CNS adverse effects, psych symptoms, tx agreement, CUD, LFTs (with EPIDIOLEX)
	Nabiximols SATIVEX x extracted THC/CBD 2.7mg THC & 2.5mg CBD per spray (peppermint flavour; poor taste) (contains alcohol) * refrigerate prior to dispensing Not available in USA.	Preferred over cannabis. ^{CFP¹⁸} ✓ advanced cancer pain (adjunctive) ✓ multiple sclerosis neuropathic pain or spasticity (adjunctive) • Spasticity may require lower doses than pain (e.g. 4-5 sprays vs >8 sprays per day).	• Spray under the tongue or into side cheek (may alternate sides). • Shake vial gently. Device requires priming (3 sprays). Initial: 1 spray sublingually HS Usual: 1 spray sublingually q4h Usual max: 12 sprays per day	3 vial pack = \$700 (\$2.60/spray) (90 spray/vial) \$84 \$504 \$1008	
	Cannabidiol EPIDIOLEX extracted CBD 100mg/mL solution ^{FDA¹⁸} (contains alcohol & sesame oil)	✓ Treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients ≥2 years of age	Seizures (Lennox-Gastaut or Dravet): ≥2yrs: 2.5-10mg/kg/dose po BID usually give before a meal • Food ^{fat/caloric} increases absorption.	Not available in Canada	
	Dronabinol MARINOL synthetic THC USA only: 2.5, 5mg, 10 cap (in sesame oil) 5mg/mL solution SYNDROS (contains alcohol)	✓ severe nausea/vomiting from cancer chemotherapy ✓ AIDS-related anorexia	Initial: 2.5mg po HS Usual: 2.5-5mg po TID-QID for chemo nausea/vomiting (~5mg/m ²) 2.5mg po BID ac lunch and supper for anorexia ^{AIDS³} Max: 20mg/day	D/C from Canadian market	
Medical Cannabis	Oral Cannabis Oils x THC/CBD in various ratios, e.g.: 25mg THC / 0mg CBD per mL 0mg THC / 20mg CBD per mL 3mg THC / 3mg CBD capsule many other formulations & potencies available. Veteran's Affairs: coverage available for some patients	No official indications. May be medically authorized in Canada to any patient for any indication. • THC detected in urine drug screen up to 4 weeks after last dose (esp. chronic/heavy users) • Oral vs inhaled: Oral has lower bioavailability (~10% vs ~25%), ¹ slower onset (30-60min vs 5-10min), ⁴ longer duration (4-8 hrs vs 2-4 hrs), ¹ & does not have respiratory risk. • Smoked vs vaped: smoking speculated to have more respiratory risk (but data limited). Vaping ~2x more potent (smoking destroys some drug via combustion). • Vaping devices: Consider a Health Canada approved vaporizer. " Marijuana Math " note: estimate only – some uncertainty! What is the estimated THC dose if 1 joint, containing 0.5 grams of 10% THC dried cannabis, is smoked? ANSWER: 500mg cannabis x 10% THC x 50% loss to combustion ≈ 25mg THC	Initial: 2-3mg of CBD +/- THC po HS (e.g. 0.1mL of 20mg/mL CBD) Usual: Uncertain due to lack of randomized trials. Titrate slowly. (Consider: dronabinol & nabiximols labelling suggest max doses of 25-30mg THC per day.) • Food increases absorption. • Consider 1 st dose at 7p.m. to leave time for assessing effect. • Consider weekend trial start (or when impairment less disastrous). Guidelines recommend avoiding smoked cannabis. ^{2,7} Initial: 1-2 puffs inhaled HS. (1 puff of joint ≈ 1-10mg THC. Variation is due to inhalation depth, puff size, THC potency, smoked vs vaped, joint size, etc.) Usual: Uncertain due to poor quality evidence. Titrate slowly. Based on market data for 2017 in Canada, medical cannabis patients titrated themselves to an average dose of 750mg dried cannabis per day. ¹⁶	\$7 e.g. 60mL bottle of oil containing 1200mg CBD ≈ \$130	
	Dried Cannabis x THC/CBD in various ratios, often to smoke/vape, e.g.: 12.5% THC 4% THC / 10% CBD 1% THC / 13% CBD many other potencies available. * refrigerate for max stability Veteran's Affairs: coverage available for some patients Trend: towards ↑ potency products. ⁵⁴ (e.g. 4% THC in 1995 → 12% in 2014) Average joint: ~0.5g dried cannabis. ^{WHO} Medical use in USA: 31 States & D.C.			In 2017 in Canada, the average medical price was \$8/g and the average street price was \$7.5/g \$12-24 for 1-2 puff HS \$180 for 750mg/day \$720 for 3g/day	

Who could be a candidate for cannabinoid therapy?

- Cannabinoids are generally not considered first- or second-line therapy for any indication. Reserve use for patients who have failed other therapies.²
e.g. may consider if tried ≥3 drugs for neuropathic pain or ≥2 drugs for palliative pain or if refractory to standard therapies for CINV, spasticity in MS or SCI, or cachexia [or refractory pediatric seizure]
- Watch for relative **contraindications** such as **pregnancy, breastfeeding**, age <21-25, a history of psychosis/schizophrenia, or substance abuse history. For more details, see [RxFiles Cannabis Q and A](#).

Prescribing/Authorizing Cannabinoids Safely

Cannabinoids are potential drugs of abuse; caution is needed when prescribing. In general, follow similar principles to prescribing opioids (see [RxFiles Prescribing Opioids Safely](#)). A summary of these principles is as follows:

- Optimize suitable non-cannabis therapies first (drug and non-drug)
- Check electronic health records (e.g. PIP in SK) at baseline and with each visit
Note: medical cannabis does not appear on PIP. Option to check order hx with Licensed Producer. Document cannabis use on local EMR (just like tobacco, alcohol, etc.).
- Baseline urine drug screen, and randomly thereafter
THC metabolite detected = THC-COOH. Note: urine drug screens in SK do not test for CBD.
- Assess risk of addiction, and monitor for cannabis use disorder →
- Ensure the patient understands cannabinoids are prescribed as a **trial**
Reasonable trial duration may be ~12 weeks.
- Obtain Treatment Agreement and Informed Consent
Search "agreement" at www.rxfiles.ca for a sample cannabinoid tx agreement. Agreement includes safe storage – especially important if kids nearby!¹⁶⁷
- Monitor for benefits & harms. **Exit Strategy:** stop (often taper) if trial unsuccessful.
Possible taper to prevent withdrawal: ↓ by 25% q1week.

Monitoring for Cannabis Use Disorder (CUD)

9% of adults who use cannabis non-medically may develop addiction (& up to 17% if started in adolescence).⁵¹

Prior to Tx: Screen for CUD

1) Options for screening:

- CUDIT-R**
specific to cannabis.⁴⁵
- CAGE Questionnaire**
short & practical.⁴⁶

2) Diagnosing:

- use DSM-5 criteria.⁵³

During Tx: Monitor for CUD

- rapid or unsanctioned dose ↑
- frequent changes needed
- wants dried cannabis only
- wants high potency THC only
- misuse of other substances
- urine drug screen: aberrant
- concerns from friends/family
- poor functioning (school/work/social)
- missed follow-up; reports of lost or stolen cannabis

In primary care,⁴⁷ watch for:

- ♦ respiratory problems
- ♦ depression/anxiety/amotivation
- ♦ issues functioning/concentrating (e.g. in studies, work, relationships)

Treating CUD:⁴⁸⁻⁵⁰

- Brief interventions
- Withdrawal management (e.g. sleep hygiene, brief symptomatic relief, ?nicotine replacement)
- Psychosocial interventions (e.g. motivational enhancement, CBT)

[Note: Pharmacologic tx, e.g. with naltrexone, appears ineffective]

Symptoms of Cannabis Withdrawal (onset 1-2 days, peak 2-6 days)

Anger, aggression, appetite change, weight loss, **anxiety**, irritability, restlessness, sleep disturbance, cannabis craving, physical discomfort.

Choosing Between Products

note: currently Canada has a "two-stream" cannabis system: medically authorized cannabis, and cannabis through retail sale.

	Prescription Cannabinoids e.g. nabilone, nabiximols	Cannabis	
		via medical authorization	via retail sale
Quality Control	Regulated. Health Canada pharmaceutical production standards in place (has Drug Identification Number).	In Saskatchewan, sellers from both medical & retail streams use the same cannabis sources (a Health Canada licensed producer). Production standards exist, including testing for pesticides & THC/CBD concentrations. ⁴³ However, similar to non-Rx herbal supplements, cannabis may have less vigorous production standards than Rx drugs.	
Dosing & Guidance	<ul style="list-style-type: none"> • Standardized. • Some indications and dosing are Health Canada approved. • Will show up on the electronic medical record (e.g. PIP in Saskatchewan). <p>Note: despite physician attempts to guide product and dosing, patients may supplement with retail cannabis against medical advice.</p>	<ul style="list-style-type: none"> • Challenging. e.g. THC in 1 puff of cannabis joint can range from 1 to >10mg. No "studied usual dose". • Physician may pick strain/ratio and max quantity allowed for patient. May limit duration, e.g. "one 60mL bottle of CBD oil, then see physician for further authorization." • Overall, less control than prescription products (e.g. "dosing interval" does not exist). 	Patient selects the product, dose, dosing interval, and route of administration. Difficult to provide monitoring, boundaries, or education.
Access	Dispensed by community pharmacy.	Exclusively by mail/courier.	At cannabis retail store; online ordering possible too.
Paperwork	Written or electronic prescription.	See Paperwork Required for Medical Cannabis box, right.	None.
Coverage	<ul style="list-style-type: none"> • Occasional private insurance coverage. • SK EDS and prior approval criteria for specific indications. 	<ul style="list-style-type: none"> • Occasional private insurance coverage (e.g. Manulife and Sunlife on a case-by-case basis as of 2018). • Veteran's affairs coverage (max 3g/day dried cannabis) <p>~\$8/gram May grow at home to ↓ costs.</p>	No coverage by any drug plans or private insurance; can't be claimed on income tax. Average price still uncertain (Ranges from \$8-20/gram)

Paperwork Required for Medical Cannabis

1. Complete medical document form (link ①). In SK, complete treatment agreement form (link ②, or visit [RxFiles.ca](http://www.RxFiles.ca) and search "agreement").⁵⁶
2. Submit medical document to Licensed Producer (link ③) who mails cannabis (dried, oil, buds, or leaves) to patient.
3. Or, patients may apply to grow their own product at home (link ④).
4. Medical document must be re-authorized at least once per year.
5. In SK, prescribers required to keep list of pts.
6. No set daily limit; max possession is lesser of 150g or 30 times daily amount.

- ① www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/info/med-eng.pdf
- ② <http://www.cps.sk.ca/IMIS/Documents/Programs%20and%20Services/Patient%20Agreement%20Template%20-%20Medical%20Cannabis.pdf>
- ③ www.hc-sc.gc.ca/dhp-mps/marihuana/info/list-eng.php
- ④ www.canada.ca/en/health-canada/topics/production-cannabis-for-your-own-medical-purposes.html

⊕=EDS in SK Ⓢ=prior approval NIHB ✕=not covered SK ⊕=not covered NIHB ⊕=NIHB palliative care 2-AG=2-Arachidonoylglycerol AEA=Anandamide CBD=cannabidiol CB1=cannabinoid receptor type 1 CB2=cannabinoid receptor type 2 CBZ=carbamazepine CINV=chemotherapy-induced nausea and vomiting CUD=cannabis use disorder MS=multiple sclerosis PIP=pharmaceutical information program TCA=tricyclic antidepressant; SCI=spinal cord injury SJW=St. John's Wort THC=delta-9-tetrahydrocannabinol

Cannabinoids: Online Extras

College of Physicians & Surgeons of Saskatchewan: The College's bylaw

The College's bylaw which regulates physician authorization of medical marihuana is now in effect. The bylaw is numbered Bylaw 19.2 of the regulatory bylaws of the College and is available at the College's website. Visit: http://www.cps.sk.ca/imis/CPSS/CPSS/Programs_and_Services/Medical_Marijuana/Medical_Cannabis.aspx. A summary of the bylaw follows:

1. The bylaw begins with a statement that there has not been sufficient scientific or clinical assessment to provide evidence about the safety and efficacy of marihuana for medical purposes. The bylaw begins with an acknowledgement that federal government regulations have authorized the use of marihuana for medical purposes.
 2. A physician cannot authorize the use of marihuana for a patient unless the physician is also the treating physician for the condition for which the patient is authorized to use marihuana. For example, if a patient is to be authorized to use medical marihuana to deal with symptoms of MS, the physician must also be the treating physician for the patient's MS.
 3. A physician must review the patient's medical history, review relevant records pertaining to the condition for which the use of marihuana is authorized and conduct an appropriate physical examination before authorizing the patient's use of marihuana.
 4. The patient must sign a written treatment agreement which contains the following:
 - A) A statement from the patient that the patient will not seek a prescription for marihuana from any other physician during the period for which the marihuana is prescribed;
 - B) A statement by the patient that the patient will utilize the marihuana as prescribed, and will not use the marihuana in larger amounts or more frequently than is prescribed;
 - C) A statement by the patient that the patient will not give or sell the prescribed marihuana to anyone else, including family members;
 - D) A statement by the patient that the patient will store the marihuana in a safe place
- Sample treatment agreement: <http://www.cps.sk.ca/iMIS/Documents/Programs%20and%20Services/Patient%20Agreement%20Template%20-%20Medical%20Cannabis.pdf>
Or visit www.RxFiles.ca and search "agreement".
5. The physician's record for the patient must include the requirements for all medical records and, in addition, contain the following:
 - A) The treatment agreement signed by the patient;
 - B) The diagnosis for which the patient was authorized to purchase marihuana;
 - C) A statement of what other treatments have been attempted for the condition for which the use of marihuana was prescribed and the effect of such treatments;
 - D) A statement of what, if anything, the patient has been advised about the risks of the use of marihuana;
 - E) A statement that in the physician's medical opinion the patient is likely to receive therapeutic or palliative benefit from the use of marihuana to treat the patient's condition.
 6. The physician must retain a single record, separate from other patient records, which can be inspected by the College, and which contains:
 - A) The patient's name, health services number and date of birth;
 - B) The quantity and duration for which marihuana was prescribed;
 - C) The medical condition for which marihuana was prescribed;
 - D) The name of the licensed producer from which the marihuana will be obtained, if known to the physician.
 7. Physicians who prescribe marihuana will be required to provide the College with the information referenced in paragraph 6:
 - A) Every twelve months if the physician has prescribed marihuana to fewer than 20 patients in the preceding 12 months;
 - B) Every six months if the physician has prescribed marihuana to 20 or more patients in the preceding 12 months.
 8. The bylaw prohibits physicians from diagnosing or treating patients at the premises of a licensed producer;
 9. The bylaw prohibits physicians who prescribe marihuana from having an economic or management interest in a licensed producer;
 10. The bylaw prohibits physicians from storing or dispensing marihuana from any location where the physician practices medicine.

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