**Template Standing Order for Dispensing Naloxone to Organizations for Subsequent Distribution**

**\*This page is information for the signing physician only and should be removed from the order before use.\***

* **This document is a template to be customized by each practitioner wishing to authorize the dispensing of naloxone to organizations for subsequent distribution as allowed by NCGS 90-12.7.**
  + **This template covers only the dispensing of the naloxone from the pharmacy to the organization.**
* **A separate standing order must be executed authorizing the distribution of naloxone by the organization to eligible candidates. The attached template requires edits before signing and use.**
* **Review all areas highlighted in yellow.**
  + **Fill in the requested information**
  + **Remove the yellow highlighting**
* **Review the area highlighted in green.** 
  + **Ensure you want all formulations included and that you agree with the provided instructions.**
  + **Make any edits you feel necessary**
  + **Remove the green highlighting**
* **Remove the “Template” watermark once you have completed the previous steps.**
* **If you have questions, please contact Amanda Moore – Amanda.fullermoore@dhhs.nc.gov**

**Naloxone Standing Order for Dispensing to Organizations for Subsequent Distribution**

This standing order signed by the (INSERT PHYSICIAN TITLE AND/OR NAME) authorizes any pharmacist practicing within the (INSERT LOCAL HEALTH DEPARTMENT PHARMACY OR OTHER PHARMACY NAME) and licensed by the North Carolina Board of Pharmacy to dispense Naloxone as directed below. Naloxone dispensing to an organization is permitted by NCGS 90-12.7. This order only covers dispensing from the pharmacy to the organization. The organization and provider must execute a separate order authorizing distribution to eligible candidates.

|  |  |  |  |
| --- | --- | --- | --- |
| **Naloxone HCI Dispensing Protocol** | | | |
| **Eligible** **Organization(s)** | * List each Organization(s) name and Primary Point of contact including phone number, mailing address and email. * Use Organization(s) name in the patient name field. | | |
| **Route(s) of Administration** | **Intranasal (IN)**  *Preferred method* | | **Intramuscular (IM)**  Inject into shoulder or thigh |
| **Medication and Required Device for Administration** | Naloxone HCl 1 mg/mL Inj.  2 x 2 mL as pre-filled Luer-Lock syringes   * Dispense 2 (two) doses   2 (two) x Intranasal Mucosal Atomizing Devices (MAD 300)  Available from: Teleflex (866-246-6990) or Safety Works, Inc. (800-723-3892) | Narcan ® 4 mg/0.1 mL Nasal Spray   * Dispense 1 x two-pack | Naloxone HCI 0.4mg/mL Inj.   * 2 x 1mL single dose vials (SDV) * 2 (two) 3 mL syringe * 2 (two) 25 G, 1 inch needle   Naloxone HCl 2 mg/2mL Inj.   * Dispense 2 (two) pre-filled syringes * 2 (two) 25 G, 1 inch needle |
| **Directions for Use** | Call 911. Spray 1 mL in each nostril. Repeat every 3 minutes as needed if no or minimal response. | Call 911. Administer a single spray of NARCAN® in one nostril. Repeat every 3 minutes as needed if no or minimal response. | Call 911. Inject the entire solution of the vial or pre-filled syringe IM in shoulder or thigh. Repeat every 3 minutes as needed if no or minimal response. |
| **Number of kits to be dispensed** | Provide either a specific number, such as 10 kits, or a maximum number, such as no more than 15 kits, to be provided at each dispensing. | | |
| **Refills** | PRN | | |
| **Individual kit labeling**  **(OPTIONAL, but recommended)** | * Place individual label on each naloxone kit containing the following:   + Tracking number if being used for data keeping   + Website for additional information and or phone number for assistance   + Instructions for use | | |
| **Special Instructions**  **(OPTIONAL, but recommended)** | * Include information here such as:   + Any logs to be kept by distribution organization and whether pharmacy should collect logs for distributed kits   + Any information/reminders that should be provided to the organization performing distribution at time of pick up from pharmacy.   + Information on name to be used on signature log at pick up (i.e. name of person presenting to pick up or distribution organization name)   + Any reminders such as storage information [Store at controlled room temperature 59°F to 77°F (15°C to 25°C). Excursions permitted between 4°C to 40°C (39°F to 104°F). Do not freeze. Protect from light.] | | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSERT SIGNING PHYSICIAN NAME AND CREDENTIALS Date Signed

INSERT PHYSICIAN TITLE

INSERT PHYSICIAN EMPLOYER (Insert date 1 year from date of signing)

National Provider ID: INSERT NUMBER Date Expires

This order is effective immediately upon signing and may be revised or revoked by (INSERT PHYSICIAN TITLE) according to his/her discretion.