Managing Opioid Concerns in the Pharmacy

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Opioid Response Network
STR-TA

Working with communities to address the opioid crisis.

- SAMHSA's State Targeted Response Technical Assistance (STR-TA) grant created the *Opioid Response Network* to assist STR grantees, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis .
- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

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Working with communities to address the opioid crisis.

- The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.
- The ORN accepts requests for education and training.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Contact the Opioid Response Network

- To ask questions or submit a request for technical assistance:
  - Visit www.OpioidResponseNetwork.org
  - Email orn@aaap.org
  - Call 401-270-5900

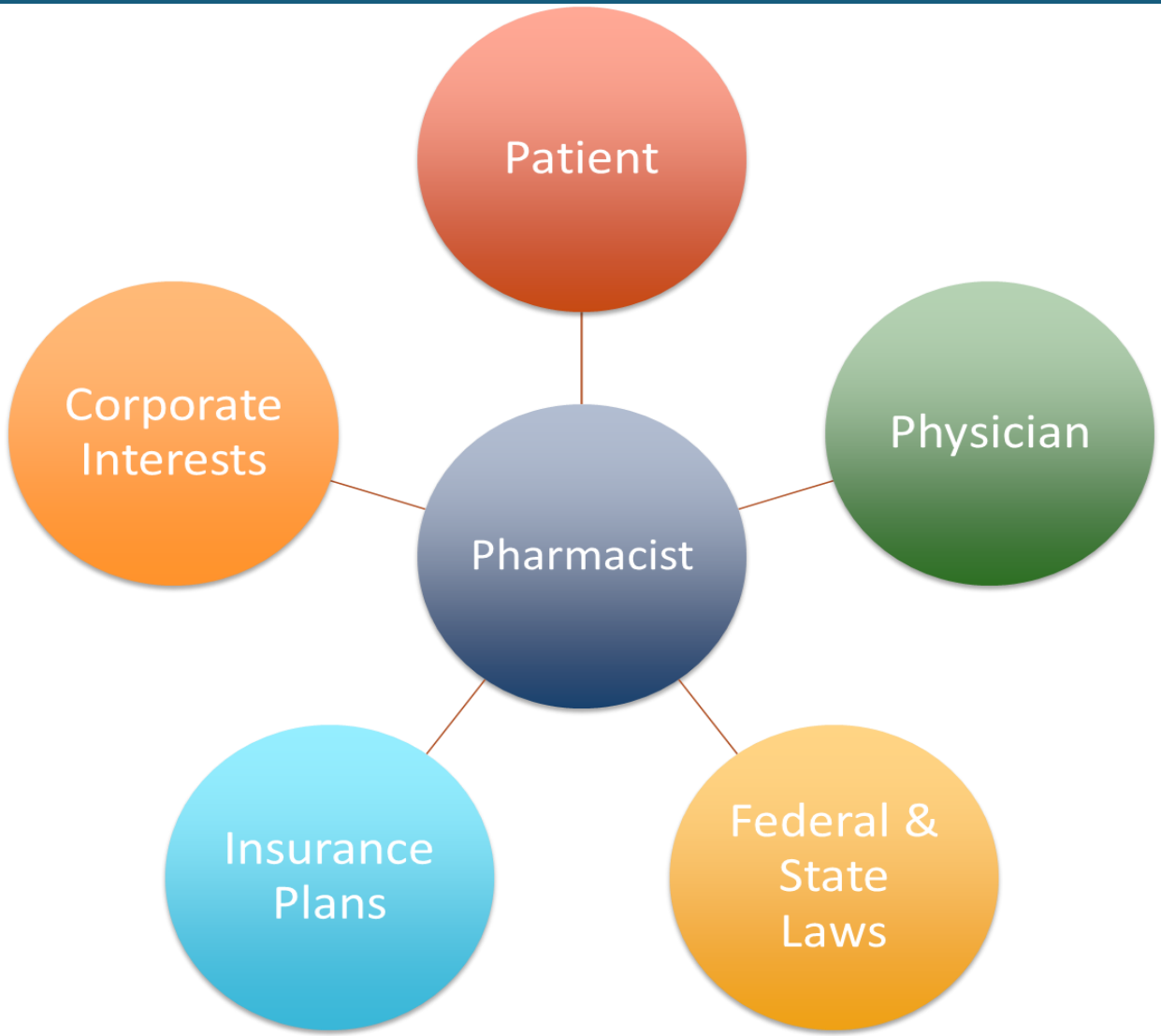
Learning Objectives

- Discuss how the CDC Chronic Opioid Guidelines affect today's pharmacy practice
- Identify "red flags" when reviewing an opioid prescription
- Apply risk management tools in a given patient scenario (SBIRT, RIOSORD)
- Describe benefits and misconceptions surrounding dispensing naloxone
- Apply motivational interviewing techniques to patient interactions

Who wants to have pain today?

CDC Chronic Opioid Guidelines

How does this affect the pharmacist?



CDC Guidelines
The Objective

Provide recommendations about opioid prescribing for *primary care* clinicians treating *adult* patients with *chronic pain* **outside of** active cancer treatment, palliative care, and end-of-life care.

Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for Chronic pain- United States, 2016. JAMA 2016. doi:10/1001/jama.2016.1464

CDC Guidelines

1. Opioids are not 1st line therapy
2. Establish and measure treatment goals
3. Discuss risks and benefits of opioids
4. Evaluate safety risk factors
5. When initiating opioid, start with short-acting
6. Start low and go slow
7. Use short courses for acute pain
8. Follow-up with chronic therapy
9. Check the PMP
10. Urine drug testing
11. Avoid CNS depressants

Example: Short course for acute pain

- Opioid treatment for post-surgical pain is outside the scope of this guideline – this is only for acute pain in primary care
- Lowest dose for the shortest period of time
- Most minor procedures/injury do not require opioid therapy as it is not more effective than NSAIDs
- Limit opioid use to 3-7 days supply if not related to surgery or trauma

See http://michigan-open.org/new-opioid-prescribing-recommendations-for2019/ for information about opioid use after common surgical procedures

Identifying “Red Flags” on Opioid Prescriptions

Pharmacist Responsibility

- Title 21 Code of Federal Regulations
  - Prescription for a controlled substance must be issued for a:
    - Legitimate medical purpose
    - By an individual practitioner acting in the usual course of his professional practice
  - Responsibility for proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a **corresponding responsibility rests with the pharmacist who fills the prescription**

Corresponding Responsibility

- Identify Red Flags
- Check PMP
- Communicate with prescriber
- Communicate with area pharmacies
- Use professional judgment

Red Flags: Patient

- Cash-paying
- New patient to pharmacy or living out-of-state
- Multiple family members present similar prescriptions from same provider
- Presenting both control and non-control Rx's, but only requesting controls be dispensed
- Returning early for refills
- Request for specific brand/manufacturer

Red Flags: Prescriber

- Out-of-state or unfamiliar provider
- Prescriber acting outside of scope of practice
- Prescriber’s DEA number has been suspended or revoked

Red Flags: Prescription

- Prescription appears altered, forged, or rewritten
- Questionable prescriber signature
- Missing essential information
- Containing excessive/unnecessary details

Red Flags: Medication Concerns

- Highly-abused cocktails, i.e. “Holy Trinity”
- Large quantities
- Therapeutic duplication (i.e. multiple long-acting opioids, multiple short-acting opioids, etc.)
- Antagonistic drugs (depressants and stimulants)
- Unavailable dosage form
- Dosages differ from typical ranges or exceed maximum recommended dose

Red Flags: Times

- Saturdays/Sundays
- Late night or near pharmacy closing time
- Requesting controlled substance + antibiotic, with lack of urgency for pick-up

Red Flags: PMP Check

- Using multiple pharmacies
- Multiple prescribers
- Inconsistent fill history

Last Line of Defense

- Options when issues arise:
  1. Resolve red flags
  2. Refuse to fill
- Exercise professional judgment
  - Contact prescriber
  - Ask additional questions
  - Document findings

Handling a Fraudulent Rx

- If confirmed to be fraudulent, contact other area pharmacies (i.e. phone/fax tree)
  - Include details about the situation, drug, and patient
  - Be timely
- Communicate with prescriber's office
  - Cross-check phone number with NPI registry
- May contact authorities
  - Police
  - State BOP
  - DEA

Case

- You are staffing your local Iowa community pharmacy on a Saturday. In the midst of your busy day, the technician receives a phone call from Trisha, an agent of Dr. Macy Cooper's office calling in a new prescription for patient Sandy Stewart for the following:
  - Promethazine/Codeine 6.25mg/10mg per 5mL cough syrup- Take 10mL PO Q4H for chronic bronchitis #273mL with 2 refills
  - Amoxicillin 500mg- Take 1 tablet PO BID #20
- Trisha also provided the technician with the patient's phone number, address, and allergies and the prescriber's address (located in IL), phone number, DEA number, and license number

Case

- Soon after, you receive a call from the patient wondering when the medications will be ready. You inquire if Sandy has insurance to bill for the medications, and she reports that she would like to pay cash. Sandy reports that she is in Iowa to visit her grandchildren and asks where your pharmacy is located. You provide her with the address and state that the pharmacy closes in 15 minutes. Sandy is OK with waiting until Monday to pick-up the medications.

Case

- **What red flags did you notice?**
  - Patient
    - Cash paying
    - Out-of-state
  - Prescription
    - High dose promethazine/codeine
    - Unusual quantity requested
    - Excessive information reported
  - Provider
    - “Agent” of provider provided phone number for callback
    - Acute medications being called in on a Saturday
    - Out-of-state
  - What next steps should you take?
    - Contact prescriber’s office on Monday

Risk Management

Aberrant Behavior

Prescription Monitoring Program

- Multiple prescribers (e.g. out of state)
- Multiple pharmacies
- Multiple cash payments
- Frequent/overlapping refills
- Drug interactions (e.g. BZD)
- Overdose Risk Score
- MME

Common Equivalents

50 MME	90 MME
Oxycodone 30mg	Oxycodone 60mg
Hydrocodone 50mg	Hydrocodone 90mg
Hydromorphone 12mg	Hydromorphone 24mg
Oxymorphone 15 mg	Oxymorphone 30mg
Fentanyl patch 25mcg/hr	Fentanyl patch 50mcg/hr
Methadone ~10mg	Methadone ~ 20mg
Codeine - 300mg (vs 166)	Codeine – can't be done
Tramadol - can't be done	Tramadol – can't be done

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf
https://opioidcalculator.practicalpainmanagement.com/

Are PMP's effective?

- The most effective programs shared the following characteristics, which all indicate signs of a robust and aggressive program:
  - Mandatory review of PDMP data by healthcare providers before writing prescriptions
  - Frequent, or weekly, updates of data
  - Provider authorization to access PDMP data
  - Monitoring of noncontrolled substances, even over-the-counter pain relievers

Fink DS, et al. [published online May 7, 2018]. *Ann Intern Med.* doi: 10.7326/M17-3074.

If you see something, say something

Patient brings new Rx for hydromorphone 4mg Q3H PRN to the counter from Dr. Ying. Already gets hydrocodone/acetaminophen 10/325 from Dr. Yang.

“I see you have a new prescription for hydromorphone from Dr. Ying. Looks like Dr. Yang has also been ordering opioid medication for you. Did you have a change in doctors? Using medication from more than one doctor could put you at risk for an accidental breathing emergency. You might want to see if you can simplify things and just have one doctor order this kind of medication.”

MD’s should be checking PMP with each new prescription, so if it happens again, may need to inform the prescribers.

SBIRT Screening

- **S**creening, **B**rief **I**ntervention and **R**eferral to **T**reatment

  How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

  Have you ever felt like you need to use your pain medication for another reason? Like feeling anxious or feeling like you need to "escape" or liking the feeling it gives you?

If negative, reinforce their healthy decisions

https://www.masbirt.org/sites/www.masbirt.org/files/documents/toolkit.pdf

STEP 2

- CAGE-AID (each “yes” = 1)

1. Have you ever felt that you ought to cut down on your pain medication use?
2. Have people annoyed you by criticizing your pain medication use?
3. Have you ever felt bad or guilty about your pain medication use?
4. Have you ever used your pain medication first thing in the morning to steady your nerves?

≤1	RISKY USE
>1	FURTHER DIAGNOSTIC EVALUATION & REFERRAL

So what if “yes”?

- “Opioids can have a lot of effects on the body, some good, some not so good. If they are not helping you be more active and leading a fuller life, if your family and friends are concerned, it might be a good idea to talk to your provider to see if he/she is concerned as well. There are plenty of long term side effects with that medicine that need to be considered.”
- “If you are needing more and more of the medicine it could mean that it just isn’t working any more and you might need to switch to something else. There are definitely long term side effects that are more common with higher doses.”

Risk Management

Safety

Drug Storage

- Cool, dry location away from kids and pets
- AVOID storing in bathroom cabinets that kids or guests can get into
- AVOID hoarding medications
  - Dispose if no longer need after surgery or other medical event
  - General rule of thumb→ dispose if received from pharmacy >1 year ago

Drug Disposal

- Local police and fire stations
  - https://odcp.iowa.gov/rxtakebacks
- National Prescription Drug Take Back Days
  - Pharmacy Take Back programs
  - https://www.deadiversion.usdoj.gov/drug_disposal/takeback/
- General Public Drug Disposal
  - Search for an Authorized Collector Location search tool on DEA website
  - Drug Disposal Fact Sheets

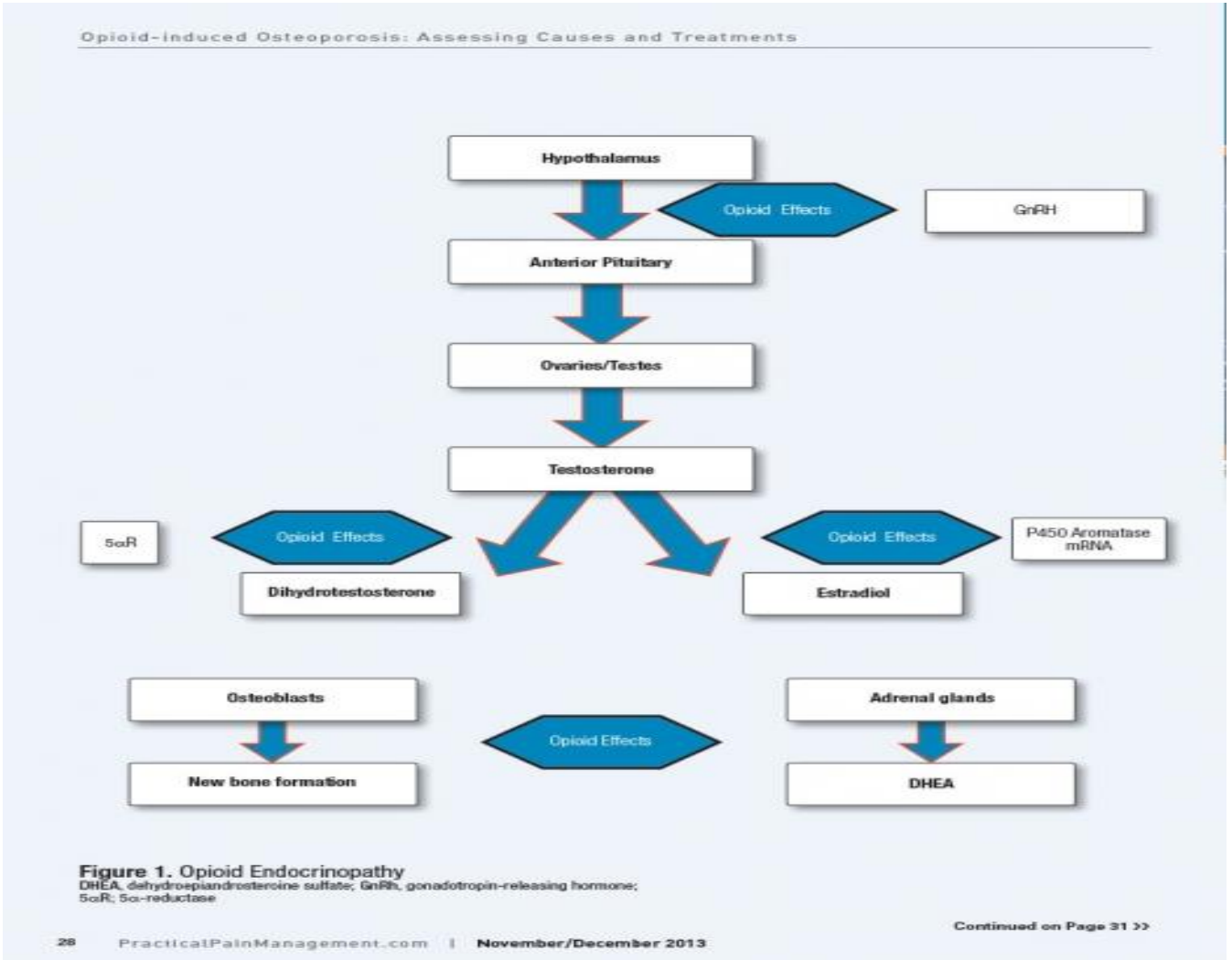
Monitoring

- Short-term
  - Constipation
  - Urinary retention
  - Itching/rash
  - Nausea
  - Sedation
  - Confusion

Monitoring

- Long-term
  - Immunosuppression (Do you get infections very often?)
  - Hypogonadism (Do you get fatigued or have problems with impotence?)
  - Osteoporosis (Have you had your bone density checked?)
  - HPA axis dysregulation (Are you checking your blood pressure?)
  - Central sensitization/hyperalgesia (Has your pain become more wide-spread over time? Have you become more sensitive to pain over time?)

Opioid-Induced Osteoporosis



https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/opioid-induced-osteoporosis-assessing-causes-treatments

Opioid-Induced Immunosuppression

- Occurs both with acute and chronic use
- Inhibits lymphocyte proliferation
- Reduces NK cell cytolytic activity
- Alters Ab-dependent cell-mediated cytotoxicity
- Suppresses hematopoietic cell development
- Apoptosis is accelerated
- Buprenorphine and tramadol appear safer

Sacerdote P, et al. Curr Pharm Des 2012;18:6034-42. Vallejo R, deLeo-Casasola O, Benyamin R. Am J Ther 2004;11:354-65.

Infection Risk

- Increased risk of invasive pneumococcal disease
  - aOR = 1.62 vs. non-opioid users
  - Greater risk with long-acting opioid (aOR =1.87)
  - Greater risk with high potency opioid (aOR =1.72)
  - Greater risk with high dosages (50-90 MME/d) (aOR 1.75)

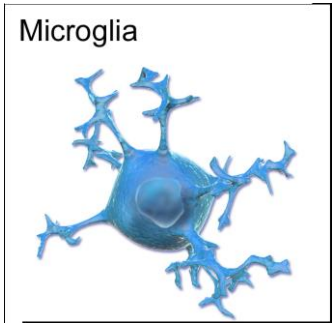
Wiese AD, Griffin MR, Schaffner W, et al. Ann Intern Med 2018;168:396-404.

Peripheral nerve injury
Trauma (physical, psychological)
Hypoxia/ischemia
Infection
Toxins
Drugs – opioids, cannabis, alcohol

Trigger, Stimulus

Peripheral nerve injury
Trauma (physical, psychological)
Hypoxia/ischemia
Infection
Toxins
Drugs – opioids, cannabis, alcohol

Pain Transmitting Substances:
NO, PG



Primary Afferents:
SP, ATP, EAAs

IL-1β, IL-6, TNF, ROS, NO, EAA, PG, ATP

Enhance Pain Transmitting Neuron Excitability

Enhance Primary Afferent Release of SP, EAA

Doyle HH, et al. J. Neurosci. 2017;37(12):3203-14; El-Hage N, et al. Immunol Invest. 2011;40(5):498-522; Cooper ZD, et al. Expert Opin Investig Drugs. 2012;21(2):169-78.

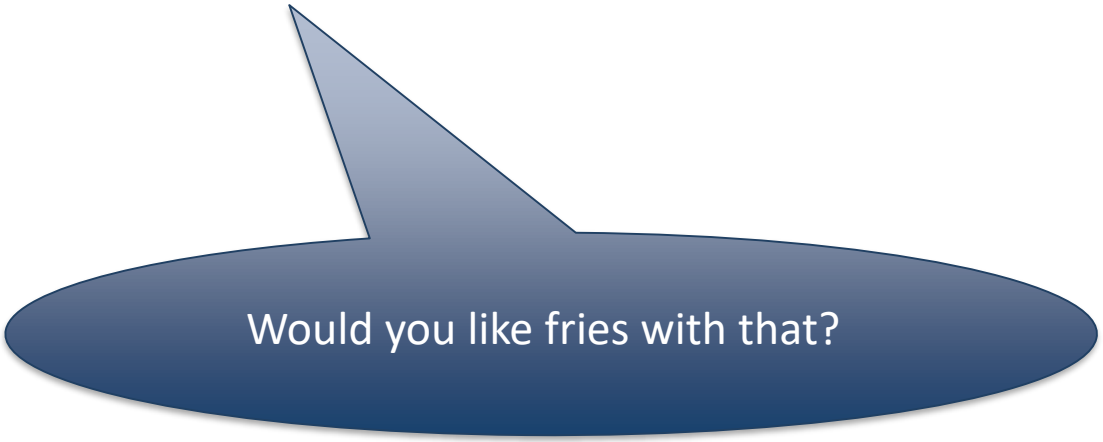
Risk Index for Overdose or Serious Opioid-induced Respiratory Depression (RIOSORD)

In past 6 months has pt had a health care visit for any of the following?	**Score**
Opioid dependence	15
Chronic hepatitis or cirrhosis	9
Bipolar disorder or schizophrenia	7
Chronic pulmonary disease	5
Chronic kidney disease with significant renal impairment	5
Active traumatic injury, excluding burns (e.g. fracture, laceration)	4
Sleep apnea	3
Does the patient consume	
A long-acting formulation of any prescription opioid or long/variable half-life?	9
Methadone (also mark Y for long-acting)	9
Oxycodone (also mark Y if using long-acting)	3
A prescription antidepressant	7
A prescription benzodiazepine	4
Is the patient's current maximum prescribed opioid dose	
>100 MME	16
50-100 MME	9
20-50 MME	5
In the past 6 months, has the patient	
Had 1 or more ED visits	11
Been hospitalized for 1 or more days	8
Total Score	115

Identify Risk Class for OSORD

Risk Index Score	OIRD probability %
0-24	3
25-32	14
33-37	23
38-42	37
43-46	51
47-49	55
50-54	60
55-59	79
60-66	75
>67	86

Naloxone



Naloxone Controversy

- Does naloxone distribution encourage increased use, higher dose and provide a false sense of security, leading to more drug being used?
  - Studies failed to prove this
  - In one trial, patients denied feeling comfortable using more heroin since having access rescue naloxone
  - One trial showed more than 50% of pts decreased drug use after a training session on naloxone and receiving a kit.

Universal Practice Standards
Naloxone Standing Order

- Purpose – Intended to ensure that naloxone may be readily obtainable by any person who is
  - An individual at risk of opioid related overdose
  - A family member, friend or other person in a position to assist a person at risk of opioid-related overdose or
  - A first responder employed by a service program, law enforcement agency, or fire department
- May be used as a prescription to obtain naloxone from a pharmacy in the event there is an inability to obtain naloxone or a prescription from an eligible recipient's regular health care provider or another source

Iowa Requirements

Pharmacy

- Develop policies & procedures for naloxone dispensing under standing order
- Ensure staff is trained on procedures.
- Compile educational materials.
- Download statewide standing order for authorized pharmacist's to sign.
- Download the Recipient Eligibility Assessment Form.
- Determine which products to offer.
- Keep assessment and dispensing records on file for 2 years from the date of assessment or dispensing

Pharmacist

- Complete 1 hour CE course.
- Sign standing order (SO)
- Assess patient for naloxone eligibility with Recipient Eligibility Assessment Form.
  - Parents must provide consent for dispensing naloxone to minors under SO
- Select product (SO excludes naloxone vials for IM administration)
- Educate naloxone recipient and/or caregiver. Obtain recipient signature of attestation.
- Fax assessment form to 515-725-4098 within 7 days, regardless of eligibility determination.

Which person should you dispense naloxone to?

1. Middle age mother of a teenager. She has heard that her son's group of friends uses "drugs and alcohol" at parties down by the river.
2. Patient with acute lymphocytic leukemia with bony metastases. He is using long-acting morphine 30mg 3 times daily and hydromorphone 4mg every 3 hours as needed.
3. Patient with osteoporosis with a history of several vertebral compression fractures. She also has diabetes and GERD. She has had asthma and allergic rhinitis since she was a child. She takes oxycodone/acetaminophen 5/325mg 4 times daily.
4. Patient using 30mg morphine 4 times daily for pain after sustaining 3rd degree burns in a garage explosion.

Patient Resources

- Prescribetoprevent.org
- Learn2cope.org
- NaloxoneWorks Facebook page
- SAMHSA’S National Helpline: 1-800-622-HELP
- www.iarx.org/naloxone

Case

- Melissa is a 46 yr old female with chronic pelvic pain for the past 10 years as well as migraines, IBS, depression and fibromyalgia
- She had not relief with NSAIDs, acetaminophen, muscle relaxants, or tramadol

First
Acknowledge that the pain is real

- “That sounds really difficult to deal with every day. And frustrating not to have good relief. I talk to a lot of people who are going through something similar so you’re not alone.”

What if we add this?

- Melissa is taking oxycodone ER 40mg tid and oxycodone/acetaminophen 5/325 up to 8 tabs/day
- She reports her pain is only getting worse with time and requests that you contact her prescriber and request an early refill on her oxycodone as she has had a really tough week.

Your response?

- Good luck with that, I'm not doing it for you
- You don't need more oxycodone, you're addicted to it
- The CDC says I can't do that
- You're on a dose equal to 240mg of morphine, are you sure it's even working for you?
- Have you been having more flares recently? It looks like you have been refilling a little early each month.

If you start a conversation…

Patient response might be…

- I have been having more flares recently. Stress is really getting to me. I'm not really sure it is helping but I don't know what else to do
- Of course I need the oxycodone but I need more for when I get flares
- I admit it's not as effective as it used to be but I've been taking it for years. Nothing else worked.
- I don't take it to get high, I need it for my pain.

Encourage positive actions

- If it's not working well for you anymore, maybe you need to talk to your provider about trying something different. Have you worked with a health coach on helping you with your stress?
- Sometimes after taking a medication for a long time it *does* become less effective and you need to make a change.
- Sometimes if you take opioid medication over a long period of time it can actually make pain worse. I hope you can avoid that. I would encourage you to sit down and talk to your provider about your increasing flares. It sounds like something needs to change because the current plan doesn't seem to be as helpful any more.

What about early refills?

- “We can’t fill this until Thursday”
- “We can have this prescription ready for you to pick up first thing Thursday morning, will you have enough medication until then?”
- “We can’t fill any more opioid prescriptions for you, you are getting things at different pharmacies and we just don’t feel comfortable”
- “We know that you need to keep taking your opioid medication to avoid withdrawal symptoms. We also notice that you are getting multiple prescriptions that may put you at risk for a breathing emergency. Can we talk about what options are available to help you right now?”

What about the providers?

- Mrs. Z is a 65 yr old who presents prescriptions for morphine ER 15mg BID and morphine IR 15mg q4hr prn (30 day supply each). “Are you having pain today? Did Dr. B say why he ordered 2 morphine prescriptions for you instead of 1?”
- PMP empty, patient reports that she has never taken an opioid before, has abdominal pain from new cancer of “female parts”. You call Dr. B’s office….

You call Dr. B's office

- "Mrs. Z has just brought in 2 different prescriptions for morphine and said she hasn't taken opioids before. I didn't see an indication on the prescription but she tells me this is for cancer-related pain. Would you like her to start with the short-acting product and see how she tolerates it?"
- "I see you didn't order any bowel regimen so I will recommend something over the counter if that's OK. I will have her give you a call if she has side effects with the morphine."

Summary

- CDC guidelines are recommendations, not mandates
- Pharmacists can
  - Watch for red flags on prescriptions
  - Monitor for risk (PMP evaluation, SBIRT)
  - Monitor for safety (short-term and long-term adverse effects)
  - Take steps to encourage safety with naloxone
  - Have positive and encouraging conversations with both patients and providers, free of stigma and confrontation.

Time to prove why we are the most trusted profession.