DISPENSING OF OPIOID DRUGS: A COMMUNITY PHARMACIST PERSPECTIVE

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CONTROLLED DANGEROUS SUBSTANCES (CDS)

- CDS includes scheduled drugs and controlled chemicals
- All CDS are dangerous but are not all equally dangerous
  - Classified based on medical usefulness, dependence, and abuse potential
  - Schedule 1 through 5
    - Schedule 1: heroin, marijuana, LSD, cocaine, etc
    - Schedule 2: oxycodone, fentanyl, hydrocodone, Adderall, etc
    - Schedule 3: testosterone, Tylenol with codeine
    - Schedule 4: benzodiazepines, tramadol, carisoprodol, etc
    - Schedule 5: Lomotil, Lyrica, Robitussin AC
- Not all CS are scheduled: Pseudoephedrine (Chemical Control)
- Not all state-scheduled drugs are DEA-scheduled: Fioricet (Butal-Acet-Caff)

FEDERAL AND STATE DISPENSING RECOMMENDATIONS

- DEA Office of Diversion recommends we verify the following:
  - The validity of the prescription (forgery?)
  - The legitimacy of the prescription (within the scope of practice)
  - The prescriptive authority of the prescriber (Valid DEA #)
  - ETC

EMPLOYER RECOMMENDATIONS

- Check IDs (Cannot fill CS prescriptions without ID#)
- Validate the prescription & Contact prescriber (especially for out-of-town prescriptions)
- Check patient profile for “too soon” fills and filling habits
- Check PDMP

WHAT IS PDMP? WHAT IS CRISP?

- PDMP (Prescription Drug Monitoring Program)is a program that monitors the prescribing and dispensing of CS. managed by the DHMH - ADAA (Department of Health and Mental Hygiene – Alcohol and Drug Abuse Administration). It was founded to reduce the misuse and abuse of prescription scheduled drugs.

- CRISP (Chesapeake Regional Information System for our Patients) serves as a statewide HIE (Health Information Exchange) for Maryland and as a portal for PDMP data.
  - Queries of Maryland, Virginia (Aug 2015), and West Virginia (Sept 2015) dispensed drugs
  - The most powerful tool we have against prescription drug abuse

THE REALITY OF THE MATTER

- I can only afford to:
  - Focus on CII drugs and CII drugs combos only
  - Check CRISP and patient profiles
  - Counsel opioid naïve patients and parents of young patients
- Biggest challenges when dealing with CDS prescriptions: Time – Time -- Time

ANECDOTE 1

- Elderly female from out-of-town gets Percocet 5/325 (oxycodone/acetaminophen) prescription from AGH doctor for pain due to abdominal pain (kidney stone??)
- Patient is a Rite Aid customer and her profile shows she is on daily morphine ER 30 mg and oxycodone 15 mg
- When asked about the status of her current therapy, she claimed she brought her meds with her.
- The prescriber, when called, claimed the patient did not disclose her current opioid therapy

ANECDOTE 2

- Middle-aged female patient comes once-monthly to pharmacy for Oxycodone prescription.
- Traits: hyphenated name, never comes too early for her fills
- Issue: Never available on CRISP when searched for

ANECDOTE 3

- Middle-aged male gets oxycodone 5 mg monthly for 30 DS
- Traits: nothing unusual, but prescription sometimes written by dentist
- Is this written in the normal/usual scope of practice?
- I discussed the issue with patient who reported that the doctor is performing a multi-step periodontal surgery on him, hence the continuous

ANECDOTE 4

- 45 yo male brings in an oxycodone prescription from a Baltimore hospital surgeon after foot or back surgery
- CRISP showed the patient has had 2 other pain prescriptions (oxycodone and Percocet) filled within the last 3 weeks with overlapping treatment periods (day-sup).
- One of the prescription was from same hospital surgeon and was paid for with cash while the other one from a local doctor was paid for using insurance. The patient could not explain why he needed the new prescription filled right away.
- A call to the surgeon was not returned. I could not fill the prescription without consulting the surgeon first
- Patient had prescription filled at another pharmacy

ANECDOTE 5

- W.R., a young adult, came to the pharmacy from the ER on "Good Friday" with two prescriptions (Vicodin and Erythromycin eye ointment) for shrapnels in his eye.
- W.R. asked whether he had to take the Vicodin since the doctor prescribed it. He said his pain level did not require Vicodin and he would rather use ibuprofen.
- It appears he was not asked what his pain level was and the ER was "slammed" that day.

- What contributed to a patient getting an opioid prescription he did not need?

ADDITIONAL MEASURES THAT COULD HELP IF THEY EXISTED

- Insurance denying claims when CII rx are filled too close to one another
- Addiction/Dependence alerts for patients who have received or are on treatment for dependence
- Built-in features in pharmacy systems that prevent early fills on CII unless some conditions are met
- Implement Delaware-like laws on Controlled drugs

HOW DO WE GET PRESCRIBERS ON BOARD

- Training and Awareness
- Pain management physicians are often the ones who write the "best" prescriptions as pain management is their sole focus
  - "Do Not Fill Before_____" dates
  - Once a month prescriptions
  - Numbering of prescriptions given on day of visit
  - Appear to assess patient therapies and habits to eventually discontinue opioid therapy and identify occurrences of dependence
- Doctors (including surgeons), Physician Assistants, and prescribing Nurses in family practice and ER settings are most vulnerable in failing to identify potential abusers and/or signs of dependency

CDC GUIDELINES ON OPIOID PRESCRIPTION

- Published on March 15th, 2016
- Targeted PCPs (family physicians and internist) in outpatient settings treating chronic pain and
- Excluded active cancer treatment, palliative care, and end-of-life care settings
- Discusses the initiation, continuation, selection, dosing, duration, discontinuation, risk assessment and consequences of opioid therapy

THE END

- Thanks to all