



CANADIAN
PHARMACISTS
ASSOCIATION

ASSOCIATION DES
PHARMACIENS
DU CANADA

Submission
to Health
Canada
Consultation
on Tamper
Resistant
Regulations

2014

Canadian Pharmacists Association



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Abbreviations

- CPhA: Canadian Pharmacists Association
- HC: Health Canada
- HCP: health care practitioner
- TR: tamper-resistant/tamper-resistance
- TRF: tamper-resistant formulation
- IR: immediate release



Canadian Pharmacists Association Introduction

The Canadian Pharmacists Association was founded in 1907 and is the national professional voluntary association providing leadership to pharmacists in all areas of practice. Our members are active in community and hospital pharmacies, long-term care facilities, home care, academia and industry. As a strong advocate for patient safety, CPhA has been actively involved in Senate consultations among many other endeavours promoting the safe and effective use of medication among Canadians. In addition to advocacy, CPhA also publishes therapeutic guides and delivers continuing education courses to empower pharmacists in providing optimal patient-centred care.

Regarding the topic of mandated tamper-resistance in opioid drug formulations, the CPhA makes the following recommendations. Please consult the section entitled “***Recommendations and Rationale***” for full details.



Summary of Recommendations

(1) TRFs for All Opioids and Stimulants

- To prevent drug abusers from switching to another non-TR drug, all opioid (e.g., hydrocodone, hydromorphone, fentanyl, etc.) and stimulant (methamphetamine, amphetamine, methylphenidate, etc.) products should be required to have TR properties. For this reason, exceptions should not be made to the proposed regulation.
- Criteria to determine which controlled substances should require TR include:
 - Current means and rates of abuse of a given product and the likelihood of a TRF reducing those rates
 - Costs (of TRF production, associated costs to health care and legal systems and potential savings to third party payers)
 - Safety of all health care professionals
 - Safety of drug abusers and risk of overdose

(2) Improved Assessment Tools and Prescribing Guidelines

- Validated assessment tools such as *Current Opioid Misuse Measure* or *Opioid Risk Tool* should be used to evaluate the risk for drug abuse and/or diversion at the patient level
- HC must work closely with professional practice groups to ensure pain assessment and opioid prescribing guidelines are evidence-based and widely utilized

(3) Narcotic Monitoring System and Law Enforcement

- HC must develop the framework for assessing TRF efficacy before implementing a legislative mandate for TR
- HC must assume responsibility for the creation, funding and implementation of a national narcotic monitoring system which reports on the following:
 - opioid prescribing/dispensing patterns
 - opioid-related adverse events
 - pharmacy theft and safety
 - Law enforcement authorities need to work together with the pharmaceutical industry, wholesalers and pharmacy operators in strengthening security and preventing prescription opioids from appearing on the streets
 - street drug usage
 - As individual products become subject to TR, HC must monitor how this affects the abuse rates of non-TR opioids and other abusable substances
- HC must make the reporting of serious narcotic-related adverse events (deaths and overdose) mandatory by law

(4) Patient Education and Public Awareness

- HC and ministries of health need to take a proactive approach by creating public awareness on the potential negative consequences of opioid use
- HCPs need to focus on taking preventative measure and treating the underlying cause of pain and/or addiction



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- Pharmacies should be included by becoming information centres through the display and distribution of pamphlets and/or posters on the addiction potential of opioids. This will allow pharmacists to initiate discussions with the public
 - Pharmacists and prescribers must work together closely to recognize signs of drug diversion, such as early refill requests or long-term use of high-dose opioids
 - Pharmacists and prescribers should work with local community initiatives to reduce the risk of abuse and diversion

(5) Harm Reduction Strategies and Improved Access to Rehabilitation

- Counselling coupled with job training, regular health care follow up and maintenance programs (e.g., methadone clinics) helps to reduce crime and prevent spread of blood-borne pathogens
- Legislators and ministries of health need to increase the number of addiction treatment centres to alleviate wait times

(6) Terminology

- CPhA supports the proposed definition of *tamper-resistance*, but notes that not all formulations may be able to meet such stringent requirements immediately
- CPhA recommends the use of the term *tamper-deterrent* to describe those products that meet some, but not all, of the criteria for *tamper-resistance* outlined in the regulatory proposal
- It must be determined whether the benefits of *tamper-resistant* formulations outweigh those of *tamper-deterrent* formulations

(7) Moving Forward

- HC must consider OxyNEO's introduction to the market in developing the timeline for the implementation of a tamper-resistance mandate
- HC must ensure continuity of care, i.e. drug availability, throughout the transition from non-TR to TR formulations
- HC must include, in the lead time, time for studies on dose equivalency across TR and non-TR formulations to allow clinicians and patients to make more successful transitions to the new formulations
- Long-acting opioids are particularly hazardous if abused and should therefore be the priority products to transition to tamper-resistant.
- HC must consult manufacturers on the topic of time required to implement a TR mandate
- TRFs must meet the needs of patients who require high-dose pain management therapy
- HC must promote the exploration of alternate avenues of pain management, including combination therapy



Recommendations and Rationale

Question 1:

Do you think that tamper-resistant products have a role to play within the Government of Canada's comprehensive strategy on addressing prescription drug abuse?

As part of a multi-faceted strategy, CPhA believes that TR products play an important role in addressing prescription drug abuse. Three types of TR agents exist: physical, aversive and antagonist (refer to **Question 8**). Due to its physical barrier, OxyNEO formulation is designed to be resistant to crushing and dissolution, preventing it from being snorted or injected. Thirty recreational opioid users in Toronto were surveyed on the attractiveness of tampering and abusing TR oxycodone. Upon completion of a tampering session and interview, participants ranked placebo reformulated OxyContin as the *least* "attractive, valuable, desirable and likely to be tampered with."¹ When TR OxyContin was first introduced in the US in August 2010, OxyContin dispensing rate in Canadian pharmacies situated close to the Detroit-Windsor Border Tunnel increased from 505 tablets/1000 population (August 2010) to 1969 tablets/1000 population (February 2011).² This may be reflective of cross-border drug-trafficking patterns and opioid users' preference for formulations that are more readily tampered.

Despite proven effectiveness in minimizing tampering potential, TRFs have resulted in unintended consequences that may have both negative public health and safety implications. Illicit drug users report changing to other opioids (e.g., heroin) as their drug of choice.³ Since the introduction of OxyNEO in 2012, the number of Ontario Drug Benefit prescriptions for Hydromorph Contin has doubled.⁴ This trend is partially due to the fact that Hydromorph Contin is covered under Ontario Drug Benefit (ODB) while OxyNEO is not. Like OxyContin, Hydromorph Contin can be crushed, injected and abused.⁵ Furthermore, users have found methods to inject OxyNEO or are simply swallowing large doses, which may result in overdose. According to HC, there is a lack of evidence to show TRFs result in less drug abuse and related harm.⁶ Thus, physicians need to take caution when prescribing TRF opioids, and TRFs should be part of the multi-pronged approach in combating illicit prescription drug use.

Pharmacists currently play a crucial part in this multi-pronged approach to curbing prescription drug abuse through various programs and initiatives. As one of the most accessible health care professionals (HCPs), pharmacists in Ontario collected 331,327 kg of expired or unwanted medications and 211,737 kg of used medical sharps in 2013.⁷ This is a result of pharmacists' actively spreading awareness on safe return programs to prevent diversion of unused medications. Pharmacists have the right to refuse to dispense a medication upon identification of misuse and/or drug diversion. Since the introduction of OxyNEO in 2012, drug abusers have changed to other opioids such as fentanyl. In response, pharmacists spearheaded fentanyl patch return programs requiring clients to return used patches to minimize illicit use.⁸



RECOMMENDATIONS

Multi-Pronged Approach

i. TRFs for All Opioids and Stimulants

- To prevent drug abusers from switching to another non-TR drug, all opioid (e.g., hydrocodone, hydromorphone, fentanyl, etc) and stimulant (methamphetamine, amphetamine, methylphenidate, etc) products should be required to have TR properties

ii. Improved Assessment Tools and Prescribing Guidelines

- HC needs to work closely with professional practice groups to ensure pain assessment and opioid prescribing guidelines are evidence-based and widely utilized
- Validated assessment tools such as *Current Opioid Misuse Measure* or *Opioid Risk Tool* should be used to evaluate the risk for drug abuse and/or diversion

iii. Narcotic Monitoring System and Law Enforcement

- HC needs to create and implement a national narcotic monitoring database
- Law enforcement authorities need to work together with the pharmaceutical industry, wholesalers and pharmacy operators in strengthening security and preventing prescription opioids from making it onto the streets

iv. Patient Education and Public Awareness

- HC and ministries of health need to take a proactive approach by creating public awareness on the potential consequences of opioid use
- HCPs need to focus on taking preventative measures and treating the underlying cause of pain and/or addiction
- Pharmacies could display pamphlets and/or posters on the addiction potential of opioids allowing pharmacists to initiate discussions with the public
- Pharmacists must work closely with prescribers to recognize signs of drug diversion, such as early refill requests or long-term use of high-dose opioids

v. Harm Reduction Strategies and Improved Access to Rehabilitation

- When coupled with counselling, job training and regular health care follow up, maintenance programs (e.g., methadone clinics) and safe injection sites (e.g., Vancouver Insite) help reduce crime and prevent spread of blood-borne pathogens
- Legislators and ministries of health need to increase the number of addiction treatment centres to alleviate wait times



Question 2:

Should all controlled-release oxycodone products be subject to a tamper-resistant regulation?

When generic OxyContin was being considered for approval in Canada, the federal government encountered a lot of resistance from the Ontario Association of Chiefs of Police and the Ontario Minister of Health. They stated “we need the federal government to help us protect public safety by stopping the introduction of generic versions of OxyContin into Canada.” HC may face similar repercussions if it requires only certain products to be TR. Evidence in support of TR includes a study involving drug abusers, who stated they were not willing to snort (92%) or inject (84%) the altered TRF products. When the TRF of OxyContin came on the market, the rate of abuse dropped from 35.6% to 12.8%, suggesting that TRFs decrease abuse potential.⁹ In addition, a rehabilitation program conducted a study of opioid abusers which found that 80% tampered with their tablets to accelerate opioid release.¹⁰ This high percentage of abusers willing to tamper with medication warrants all oxycodone tablets to require TR.

Those who oppose TRFs believe that making all formulations TR will not reduce abuse, but divert addicts to a different, potentially more harmful or potent, drug. According to a *NEJM* survey, the abuse of oxycodone fell as the rates of abuse rose from 20% to 32% for high-potency fentanyl and hydromorphone, respectively. Heroin abuse rates nearly doubled when OxyContin use dropped from 47% to 30%. With regards to only making certain strengths TR, abusers are likely to abuse the lower strength non-TR formulations, considering many were willing to switch opioids altogether. If abusers decide to switch to a lower strength formulation or to a different drug, there is an increased risk of overdose due to experimentation, leading to a greater overall risk to public health and safety.¹¹

RECOMMENDATION:

- All oxycodone products should be subject to TR; however HC must monitor how this would affect the abuse rates of other non-TR opioids

Question 3:

Are there other controlled substances, or classes thereof, that you feel should be required to have tamper-resistant properties before they are allowed to be sold in Canada? If possible, please provide a rationale or evidence to support your response.

One of the challenges of curbing prescription drug abuse is the vast selection of opioids and stimulants available on the market and in the streets. With 15 active pharmaceutical ingredients including opioids such as hydrocodone, hydromorphone and fentanyl, and stimulants such as methamphetamine, amphetamine and methylphenidate, dozens of specific products are available with abuse potential.^{12,13} In fact, in the last 10 years, the rate of opioid prescribing in Canada has doubled.¹⁴

As seen in the case of the US release of OxyNEO in 2010, a TRF has the potential to reduce the abuse rate of a specific drug. Between 2009 and 2012, 2,566 opioid abusers in the US were given self-administered surveys.¹⁵ Despite the drop in abuse potential and preference for OxyNEO, TRFs have not been shown to stop a user from drug abuse altogether. Instead, there was a rise in abuse of hydrocodone, fentanyl, hydromorphone and heroin. Of the 103 participants interviewed, 66% transitioned to another opioid and 24% managed to overcome the TRF. Thus, long-acting opioids that are not made tamper-resistant would become the new drug of choice.¹⁶



This unanticipated effect of users switching to heroin may have a greater impact on public health and safety. Since heroin is readily available and easily abusable at lower costs, there has been a surge in criminal network activities to supply the void created by OxyNEO's release in Canada.¹⁷ It is also important to note that substance abuse is a complex issue and does not only revolve around opioids. Opioid use is generally associated with other substances, most commonly alcohol and cocaine.¹⁸ Furthermore, opioids are prescribed not only for complex conditions such as chronic pain, but also simple procedures such as dental extractions.¹⁹ With 30 - 40% of opioid prescriptions in Ontario written for dental procedures, the Ontario College of Dental Surgeons is creating opioid prescribing guidelines.²⁰

RECOMMENDATION:

- To prevent drug abusers from switching to another non-TR drug, all opioid (e.g., hydrocodone, hydromorphone, fentanyl, etc) and stimulant (methamphetamine, amphetamine, methylphenidate, etc) products should be required to have TR properties

Question 4:

What criteria or evidence should be taken into consideration when determining which controlled substances should require tamper-resistant properties in order to be sold in Canada?

A major consideration for determining which opioids require TR formulations is the cost-benefit analysis. There are respective costs of developing new TRFs and retaining non-TRFs in place. First off, it would require a large financial commitment by manufacturers to produce TRF technology and new packaging. In contrast, the non-TRFs also add financial burden to the health care and legal systems. This includes the cost of treating abuse, cost of medical complications such as HIV, Hepatitis C and other infections,²¹ costs to the of criminal justice system and the cost of lost productivity attributable to opioid abuse. Although there is not yet evidence of TRF decreasing abuse rates, it is reported that replacement of OxyContin with OxyNEO needs to reduce abuse rates by 18-30% to be economically neutral. A 2006 US study also concluded that third party payers could potentially save \$US 0.6-1.6 billion per year for introducing an TRF opioid.²²

Another consideration is the safety of pharmacy and medical facility staff in regards to intimidation, violence, break-ins and opioid theft. No data are available for Canada; however, in the US, between 2000 and 2003, approximately 13,000 occurrences of theft or loss of controlled substances were reported. This included millions of doses of morphine, methadone, hydromorphone, meperidine, fentanyl and nearly 4.5 million doses of oxycodone.

Prescribers may fear legal liability for prescribing non-TRF opioids when other TRF substances exist.²³ However, if many TRFs become available, physicians may feel that these substances are safe and cannot be abused, thereby increasing the number of prescriptions for these drugs.²⁴ Considerations regarding which substances require TR formulations should include the rate at which it is abused, the potential for abuse if other opioids switch to TRF and the safety concerns for prescribers and pharmacy staff.



RECOMMENDATIONS:

- Criteria to determine which controlled substances should require TR include:
 - Costs (of TRF production, associated costs to health care and legal systems and potential savings to third party payers)
 - Current abuse rates of different opioids and the likelihood of a TRF reducing those rates
 - Safety of all health care professionals
 - Safety of drug abusers and risk of overdose

Question 5:

Are the criteria outlined above for tamper-resistant properties appropriate?

The criteria outlined above are certainly an appropriate definition of tamper-resistance, and encompass all the relevant facets of abuse deterrence (aversion, physical barriers and antagonists). If such a stringent definition is to be used, however, it may be beneficial to distinguish between formulations which are *tamper-resistant* (those which meet all of the above criteria) and those which are *tamper-deterrent* (those which meet only a portion of the above criteria). There is no question that drug formulations meeting the outlined criteria will aid in reducing drug diversion. However, formulations that meet only a subset of these criteria may also generate significant, positive impacts on abuse-deterrence. In that sense, *tamper-deterrence*, if not tamper-resistance, may be said to have been achieved without having met all the criteria outlined above. When the new formulation of OxyContin was introduced to the market, the rate of oxycodone abuse dropped from 35.6% to 12.8%, suggesting that *tamper-deterrent* formulations can be effective. Whether a subset or the entirety of the criteria above must be met for a formulation to qualify as *tamper-resistant* could depend on the impact of each abuse deterrent tactic incorporated into the formulation, and formulations should be evaluated on an individual basis to assess their true abuse-resistant potential.

RECOMMENDATIONS:

- CPhA supports the proposed definition of *tamper-resistance*, but notes that not all formulations may be able to meet such stringent requirements immediately
- CPhA recommends the use of the term *tamper-deterrent* to describe those products that meet some, but not all, of the criteria for tamper-resistance outlined above.
- It should be determined whether the benefits of *tamper-resistant* formulations outweigh those of *tamper-deterrent* formulations

Question 6:

How can tamper-resistant products be assessed in terms of their ability to effectively deter abuse?

The development of a strategy to quantitatively measure the impact of TRFs should predate the implementation of any legislative mandate for tamper resistance. Four key areas must be monitored to assess tamper-resistance: opioid prescribing/dispensing patterns, opioid-related serious adverse events, pharmacy safety and street drug usage. The benefits of this assessment are two-fold: not only will the efficacy of tamper resistance be made concrete, but areas in which drug diversion can be improved will be exposed. With narcotics being a federally regulated area, HC will have a critical role to play in the



creation and implementation of the monitoring network to accomplish this and, especially, in mandating its use.

A successful TR product should produce an observable decrease in the demand for its active ingredient immediately after the entry of the TRF formulation onto the market. It could also inadvertently lead to a shift in drug diversion to a different, more abusable drug or formulation. This is why monitoring prescribing patterns of both TRF- and non-TRF-opioids is of critical importance in TRF efficacy assessment. HC has a role to play in this monitoring process. Collecting electronic dispensing reports from pharmacies, allocating resources into narcotic surveillance and identifying high volume prescribers are three of the key areas in prescription monitoring that must be addressed. Tracking Canadian drug sales may also aid in understanding the full narcotics picture.

A study published after the entry of OxyContin to the Canadian market tracked opioid-related adverse events and fatalities through coroner's reports and hospital records.²⁵ The study found a trend of these events *increasing* with the introduction of the high-dose product onto the market; this tracking must continue with the introduction of TRFs, as they are expected to reverse this increasing trend. It would also be beneficial to make the reporting of narcotic-related overdoses and deaths mandatory for hospitals.

Monitoring pharmacy break-ins and street drug abuse will help assess whether the abuse appeal of the newly tamper-resistant drug has decreased, and whether that appeal has been displaced. TRFs should promote a *decrease* in narcotic theft. Recent findings seem to indicate that tamper resistant formulations may shift abusers from prescription-drug abuse to street drug abuse. Monitoring for this in street drug trends will allow HC and other implicated organizations to provide support and resources where they are most necessary.

RECOMMENDATIONS:

- Develop the strategy for assessing efficacy before implementing legislative mandate for TR
- HC must assume responsibility for the creation, funding and implementation of the necessary monitoring systems
- Monitor the following:
 - opioid prescribing/dispensing patterns (anticipate decrease)
 - opioid-related adverse events (anticipate fewer adverse events)
 - pharmacy safety (anticipate fewer break-ins)
 - street drug usage (observe shift in drug abuse)
- Make the reporting of narcotics-related adverse events mandatory by law

Question 7:

What is the appropriate lead time required for the pharmaceutical supply chain to prepare for a requirement that a drug containing a controlled substance, or class thereof, have tamper-resistant properties in order to be sold in Canada, if that drug is already on the market?

CPhA cannot set a definitive timeline for this process. In the case of OxyContin, it appears to have taken two years to transition from the extended release formulation to the tamper-deterrent OxyNEO. HC



must review this process, chronicling its successes and failures to determine what can be improved upon during any transitions in the near future.

Lead time must allow for clinical trials that will comparatively assess the pain control of non-TRFs vs. TRFs at bioequivalent doses. If significantly different, and high-profile education campaign and a conversion chart should be made available to health care professionals upon the release of the TR formulation. Pharmacists, as clinicians, assume responsibility for the continuity of care for their patients, and this should be a priority in determining the lead time required for this transition. This includes time required for physicians to transition their patients to TR formulations. Expanding pharmacists' scope of practice to include this transition from standard drug formulations to TRFs of equivalent dose could expedite the process.

With regards to the time required to develop TRF technology, a discussion must be conducted with drug manufacturers. Again, the main priority must be that patients with legitimate needs for pain control retain access to pain management therapy throughout the process. Lead time for changes to manufacturing facilities and procedures, as well as the time required for HC to process drug approval, must be considered.

Although not related specifically to lead time, certain products should be prioritized when considering the transition process from non-TR to TR formulations. These products include all long-acting opioid formulations. A long-acting oxycodone 80mg tablet has 16 times the amount of oxycodone compared to an immediate release (IR) starting dose (5mg). Other drugs, such as long-acting hydromorphone, are also available at concentrations several multiples above the starting IR dose. As these formulations have extremely high hazard potential, it is especially critical that long-acting formulations be made TR. These products should be the first to undergo changes in formulation.

RECOMMENDATIONS:

- CPhA cannot set a definitive timeline for this process
 - HC must review the successes and failures of the OxyNEO transition
- Lead time must allow for clinical trials that will comparatively assess the pain control of non-TRFs vs. TRFs at bioequivalent doses
 - If significantly different, a conversion chart should be made available to health care professionals upon the release of the TR formulation
- Lead time must allow for physicians to transition their patients to TRFs
- With regards to the time required to develop TRF technology, a discussion must be conducted with drug manufacturers
 - Lead time for changes to manufacturing facilities and procedures, as well as the time required for HC to process drug approval, must be considered

Question 8:

Beyond their potential ability to curb abuse, what other impacts both positive and negative could potentially result from mandating tamper-resistant properties as a condition of sale on select pharmaceuticals that are at high risk for abuse and diversion?



Regardless of TR strategy, TRFs will result in an increase in acquisition price of opioid therapy. This may create financial burden for patients paying out of pocket. If patients paying out of pocket are required to allocate more money to opioid prescriptions, repercussions may occur in other areas. This may include re-appropriation of funds usually reserved for nutrition and housing, ultimately leading to an overall decreased health status. Non-adherence or unwarranted tapering could occur if patients attempt to save money by decreasing their dose, leading to inadequate pain control.

Three approaches have been developed to confer TR in the hopes of preventing abuse; physical barriers, aversive agents and opioid antagonists. Each strategy has its unique benefits and disadvantages, described below. A TR tablet could employ one or all of these methods to confer resistance. It is important to note that regardless of patient compliance or TR strategy used, there is a possibility of adverse effects. Also, none of the present strategies for TR have been validated by long-term data and post-marketing surveillance demonstrating abuse deterrent success.

i. Physical Barriers

Physical barriers are drug properties that prevent it from being crushed or cut (for oral euphoric or snorting purposes) and dissolved (for injecting purposes). These obstacles are unique as they may benefit both abusing and non-abusing patients. Non-abusers who may suffer from cognitive impairment (e.g. dementia) and accidentally chew or crush their tablets are protected from undesired euphoric effects. However, not being able to cut, crush or chew a tablet may be problematic for patients with dysphagia (difficulty swallowing) or phagophobia (fear of swallowing) who do so to simplify swallowing. This problem is applicable to all TR strategies when they tampered with.

ii. Aversive Agents

Aversive agents are isolated from the active ingredient and are released upon tablet crushing, chewing or chemical tampering. This property seeks to make an opioid formulation less attractive to abusers, although research suggests that these factors do not deter abuse among the public. A benefit to this formulation is that it may be the only TR method to discourage excessive oral consumption as aversive effects are additive. The drawback to this is that patients who legitimately require high dosages are at an increased risk of side effects due to this additive property, possibly rendering this formulation unsuitable.²⁶

iii. Antagonistic Agents

Opioid antagonists function much like aversive agents. They are not designed to work in tandem with the opioid, but are only released to neutralize the agonist if the tablet is tampered with. Theoretically, the advantage of such a strategy is its safety – antagonistic effects should not impact pain relief or induce aversive effects. They have actually been used in the past to decrease the constipating side effects of opioids. Antagonistic agents could potentially allow pain sufferers to tamper with their doses (dysphagia suffers for instance) while retaining their therapeutic effect, although possibly not to the same extent. With regards to users seeking euphoric effects, antagonistic agents will render them unable to achieve a ‘high’.

RECOMMENDATIONS:



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- Evaluate the need for developing strategies when developing a formulation
 - Consider the needs of both abusers and non-abusers when incorporating aversive agents and physical barriers into a formulation

Question 9:

Are there particular circumstances or scenarios under which exceptions to the proposed regulations should be authorized?

Exceptions to the proposed regulation will almost certainly negate the potential benefits of tamper-resistant formulations and may act as gateways to opioid abuse. That being said, all tamper resistant formulations must be developed with a balance of patient outcomes and public safety in mind. Chronic pain-sufferers who legitimately need high-dose pain relief cannot be ignored and there must be recourse for them if abuse-deterrent formulations limit their pain management too strictly. This may mean simply developing a broader range of doses than what is currently available, but it may mean limiting the aversive effects of high-dose opioids and/or requiring special authorization for their prescribing and coverage. Multi-drug approaches to pain management may also have an increasingly important role to play in pain-management.²⁷ Comprehensive studies show a lack of good evidence for long-term use of opioids in chronic pain conditions such as arthritis. Some advocates of opioid deprescribing argue that it is aggressive marketing by pharmaceutical companies that has led to the myth that opioids are safe and effective with limited addiction potential.²⁸ This is an area that must be addressed – if other safe and effective means of pain control can be identified, the need for exceptions to tamper resistance may be inexistent. All in all, it is clear that much discussion remains to be had on the topic on tamper resistance in pain management, and patient, dispenser, prescriber and drug developer perspectives must all be heard.

RECOMMENDATION:

- Exceptions should not be made to the proposed regulation

Question 10:

Are there any other comments you wish to offer to inform the Government's position on this issue?

Details of Multi-Pronged Approach

CPhA applauds the Government's initiative to help ensure the safety of patients and health care providers. We strongly recommend viewing the proposed regulation as one part of a multi-pronged approach that will involve multiple stakeholders to bring about changes quickly and change the system so that patients with legitimate needs will be helped and those engaging in diversion and abuse will be identified and directed to appropriate support programs.

The following are the components of the multi-pronged approach we recommend:

i. TRFs for All Opioids and Stimulants

Refer to **Question 3**



ii. Improved Assessment Tools and Prescribing Guidelines

As the country with the second highest opioid drug use, Canada's approach to chronic pain management and addiction treatment and avoidance is failing.²⁹ If long-term opioid treatment is indicated, written compliance agreements should be signed and frequent confirmatory urinalysis should be conducted. With opioid-related deaths on the rise, HC needs to work closely with professional practice groups to ensure proper pain assessment and opioid prescribing guidelines are in place. High-volume opioid prescribers such as dentists need to adhere to evidence-based prescribing guidelines and reserve long-term opioid use for severe chronic pain. Patients identified with mild to moderate pain or increased abuse risk should be advised to take over-the-counter analgesics post dental surgery.³⁰ Before initiating opioid therapy for chronic non-cancer pain, validated assessment tools such as *Current Opioid Misuse Measure* or *Opioid Risk Tool* should be used to evaluate the risk for drug abuse and/or diversion.³¹

RECOMMENDATIONS:

- HC must work closely with professional practice groups to ensure pain assessment and opioid prescribing guidelines are evidence-based and widely utilized
- Validated assessment tools such as *Current Opioid Misuse Measure* or *Opioid Risk Tool* should be used to evaluate the risk for drug abuse and/or diversion

iii. Narcotic Monitoring System and Law Enforcement

In efforts to track and prevent acts of drug diversion such as double doctoring, polypharmacy and forgeries, provincial/territorial regulatory bodies and ministries of health have implemented different monitoring systems. Triplicate Prescription Programs (TPPs) exist in various jurisdictions across Canada. In Alberta, pharmacists, dentists and physicians teamed up to create a TPP to monitor risk of abuse and diversion of certain prescription medications.³² British Columbia's PharmaNet system is a centralized prescription network introduced in 1995. After 6 months of PharmaNet implementation, there was a 32.8% decrease in inappropriately filled opioid prescriptions in patients on social assistance. This trend was also recorded for patients aged 65 and over.³³ Introduced in 2012, Ontario's Narcotic Monitoring System (NMS) provides pharmacists with real-time Drug Utilization Review (DUR) functionality. When a controlled substance is dispensed at a community pharmacy, the NMS conducts a DUR in real-time and analyses the current dispensing record against past records.³⁴ Possible alert messages include: "May be double doctoring," "Polypharmacy use indicated," "Duplicate drug other pharmacy," or "Refill too soon/late." However, these messages are often not specific and, for this reason, the DUR message is rarely the information that leads the pharmacist to make further enquiries. If perfected, this tool could become an excellent screening tool for pharmacists in identifying polypharmacy and drug diversion.

Going forward, HC needs to create and implement a national narcotic monitoring database.

Lastly, with pharmacy thefts on the rise, law enforcement authorities need to work together with the pharmaceutical industry, wholesalers and pharmacy operators in strengthening security and preventing prescription opioids from making it onto the streets.



RECOMMENDATIONS:

- HC must create and implement a national narcotic monitoring database
- Law enforcement authorities must work with the pharmaceutical industry, wholesalers and pharmacy owners and staff in strengthening security and preventing prescription opioids from making it onto the streets

iv. Patient Education and Public Awareness

In combination with the aforementioned methods, HC and ministries of health need to take a proactive approach by creating public awareness on the potential consequences of opioid use. Education campaigns should deliver a message that resonates with Canadians without the use of fear mongering tactics. HCPs need to focus on taking preventative measures and treating the underlying cause of pain and/or addiction. Pharmacies could display pamphlets and/or posters on the addiction potential of opioids allowing pharmacists to initiate discussions with the public. Community pharmacists work at the frontlines and are perfectly positioned to assess adherence and identify abuse behaviour. Pharmacists must work closely with prescribers to recognize signs of drug diversion, such as early refill requests or long-term use of high-dose opioids. Furthermore, according to the Manitoba Oxycontin Working Group, education campaigns also need to make the public aware of the health and legal ramifications of sharing their prescription medications.³⁵ Lastly, there is an increasing concern of prescription opioid abuse in the Aboriginal population.³⁶ This indicates an urgent need for increased funding in harm reduction and rehabilitation programs.

RECOMMENDATIONS:

- HC and ministries of health must take a proactive approach by creating public awareness on the potential consequences of opioid use
- HCPs must focus on taking preventative measures and treating the underlying cause of pain and/or addiction
- Pharmacies should display pamphlets and/or posters on the addiction potential of opioids allowing pharmacists to initiate discussions with the public
- Pharmacists must work closely with prescribers to recognize signs of drug diversion, such as early refill requests or long-term use of high-dose opioids

v. Harm Reduction Strategies and Improved Access to Rehabilitation

In light of increasing opioid-related deaths, it is evident that current anti-opioid abuse initiatives have not proven to be entirely effective. Self-help options (e.g., books and telephone lines) and community-based programs (e.g., counselling centres) may provide partial benefit to those in early stages of opioid addiction. When coupled with counselling, job training and regular health care follow up, maintenance programs (e.g., methadone clinics) and safe injection sites (e.g., Vancouver Insite) have proven to be effective in reducing crime and preventing spread of blood-borne pathogens.³⁷ Since Insite's opening in Vancouver, there has been a 35% reduction in fatal overdoses within 500 meters of the facility as compared to a meagre 9% reduction in the rest of Vancouver.³⁸ Detoxification facilities help rehabilitate opioid abusers in a safe and supportive environment staffed by HCPs and social workers. Unfortunately,



the average wait time for admission into a publicly funded rehabilitation centre in Ontario is one month, with as long as a 3-month wait in Waterloo.³⁹ In order for long-term opioid abusers to rehabilitate and live fulfilling lives, it is imperative that legislators and ministries of health increase the number of addiction treatment centres to alleviate wait times.

RECOMMENDATIONS:

- When coupled with counselling, job training and regular health care follow up, maintenance programs (e.g., methadone clinics) and safe injection sites (e.g., Vancouver Insite) help reduce crime and prevent spread of blood-borne pathogens. Hence, HC should provide a Framework for these services in the interest of public safety and the minimization of drug diversion.
- Legislators and ministries of health need to ensure addiction treatment centres are adequately funded and staffed to ensure accessibility by those in need.



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