Opioid drugs: Current strategies to prevent diversion and ensure appropriate use

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Disclosures

• Speaker/Honoraria for CCAC, CMHA, Memorial University of Newfoundland’s School of Pharmacy, Pharmasave Ontario, Reckitt-Benckiser
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• Pharmacist Manager and Owner of Westboro Pharmasave
• Vice President of Business Development and Public Relations, and Owner of Respect Rx Pharmasave
• Member of National Advisory Council on Prescription Drug Misuse through the Canadian Centre on Substance Abuse
Learning objectives

• Overview of the current drugs of abuse
• Misuse at the community pharmacy and how it presents
• Community pharmacists' role in preventing diversion and ensuring appropriate use - “five minutes to make a difference"
• Specific programs and tools to help pharmacists prevent diversion
It’s our problem

- **350,000 Canadian kids have taken prescription medications NOT prescribed to them.**
  
  *PDFC estimate*

- **In other words, 12% of Canadian teenagers have admitted to taking opioid prescription drugs (painkillers) to get high, and 70% of them say they stole the pills from home.**

  *Source: CAMH – Ontario Student Drug Use and Health Survey (2013 OSDUHS)*
Prescription drugs of abuse

- Opioids … any and all
  - fentanyl, oxycodone, heroin, hydromorphone and even buprenorphine/naloxone
- Stimulants
  - methylphenidate, amphetamine
- Benzodiazepines
- Zopiclone, zolpidem
- Gabapentin, pregabalin
- Quetiapine
- Bupropion
Addiction

• External substances (or behaviours) take over the built-in reward systems found in our brains
• These systems are there to promote our survival
• Loss of control of use
• Consequences (use despite harm) in bio-, psycho-, social, spiritual domains
• Craving
• Compulsive use and misuse (snorting, chewing patches etc.)
Addiction

- Drug use as conditioned, “trained” behaviour (operant conditioning)
- Drugs are addicting not only because they feel good but because they are reinforcing
- The shorter the time between the behaviour and the reward, the more strongly reinforcing it is (swallowing pill whole → chewing → snorting → injecting/smoking)
DSM-V opioid use disorder

- Larger amounts, longer periods
- Can’t cut down
- Significant time spent obtaining, using, recovering
- Craving / strong desire to use
- Failure in role obligations (school, work, home)
- Use despite social or interpersonal problems
- Important activities given up (social, occupation, recreational)
- Use when it is physically hazardous
- Use despite knowledge of physical or psychological problem
- Tolerance
- Withdrawal

DSM-V opioid use disorder

- Mild: Two to three symptoms
- Moderate: Four to five symptoms
- Severe: Six or more symptoms
Addiction

- Prevalence of opioid addiction in general population is 0.05% to 0.2% (1 out of 500-2000 people)
- In chronic pain opioid-treated population opioid addiction may be as high as 3% - (Fishbain 2008)
- Opioid drug misuse may be as high as 11% among opioid prescribed patients (meta-analysis)
  - Could be “pseudo-addiction” corrected when dose is adjusted
Risk factors for addiction

• Family history of addiction
• Gender – male 2x
• Having other psychological problems
  – anxiety, depression and loneliness
• Peer pressure and social dynamics – youth, poverty and education
• Lack of family support
  – Parental supervision or attachment
• Taking an addictive medication (opioid)
• BUT EVERYONE IS SUSCEPTIBLE
Pain or addiction in your pharmacy?

- Hard to distinguish
- More than one excuse – investigate opioid use disorder
  - early fill
  - lost medication
  - remember pseudo-addiction
- Behavioural changes
  - aggressive attitude
  - withdrawal symptoms
Opiate withdrawal

- Caused after the amount of opiate is significantly decreased or abruptly discontinued after regular use
- The body has adapted to the presence of the drug and cannot re-adapt quickly enough to its absence at the mu receptor
Opiate withdrawal

- Some symptoms may include:
  - Insomnia
  - Runny nose
  - Muscle aches
  - Dilated pupils
  - Restlessness
  - Depression
  - Anxiety
  - Sneezing
  - Discomfort
Pain or addiction in your pharmacy?

- Be prepared for disagreements with your patient if you think there is a problem, and the patient doesn’t
  - Plan (quiet place, extra staff)
  - Show compassion
  - Refer to local addiction treatment center
- Ignorance or indifference towards a diagnosis does not serve your patient
  - Respect, respect, respect
- Addiction is an illness that robs quality of life and is sometimes fatal
- Addiction responds to the right treatment
The pharmacist’s role in prevention

- Assess risk of addiction while counselling
- Apply expanded scope
  - Reduce quantity
  - Therapeutic substitution
  - Increase intervals
- Educate on the dangers
  - While counselling
  - During medication reviews
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The pharmacist’s role

• Be the **solution** not the **problem**
  – Provide options
    • Structured opioid therapy (daily dispensing)
    • Methadone (Methadose) or buprenorphine (suboxone) maintenance treatment
    • Abstinence based treatment
  – Communicate and document
    • Call prescriber
    • Call family and friends
    • Find treatment
  – Support withdrawal
Opiate withdrawal protocol (CAMH)

Name of addiction service

**OPIATE WITHDRAWAL PROTOCOL**

(orders taken from the Treatment of Substance Use Disorders Pocket Reference*)

Clonidine 0.1 mg
1 tab qid for 3-5 days then
1 tab qid prn for 3-5 more days (warn about symptoms of postural hypotension and drowsiness) HOLD if symptoms of hypotension.

Dimenhydrinate 50 mg
1 tab q4h prn for nausea.

Loperamide 2 mg
2 tabs following initial loose bm then 1 tab following each subsequent loose bm up to maximum of 8 tabs per day.

Ibuprofen
Pain Management

As our policies indicate all prescriptions and over the counter medications require an order. Please indicate via fax or telephone call with a prescription to our centre if you wish your client to use the above medications for opiate withdrawal.

Staff Signature
Working with physicians

• Be the expert - because you are
  – Provide tapering schedule (Canadian tapering guidelines via CAMH)
• Physicians may feel guilt or frustration with the patient
  – Feel as if they started the problem
  – May have “fired” the patient
Do not confuse education with intelligence...when dealing with addiction!
Fentanyl patch return

• Return all patches before more are dispensed
  – Generic vendors provide return sheets
• Patch 4 Patch initiative
  – Ontario Association of Chiefs of Police document
    • http://www.oacp.on.ca/Userfiles/Files/NewAndEvents/PublicResourc
eDocuments/Master%20Patch%204%20Patch-FINAL%202014.pdf
Max 30 day supply with opioids

- Medical directive from local prescribers
  - Ability to adapt the prescription to no more than a 30 day supply DESPITE what is written
  - Used at your pharmacy
  - Exceptions granted
  - Helps family physicians feel comfortable with prescribing
  - Document and signed agreements helpful
Restrict OTC codeine

- Varies among regions
- Stop selling 200s of generic versions
- Make them expensive
- Ask for ID and produce a pharmacy label
- Link with provincial narcotic monitoring programs
  - Follow national program
“Take it back” programs

• Be a champion for this program in your community
• Follows most provincial stewardship programs
• Partnership for a Drug-free Canada (PDFC)
  – National Prescription Drug Drop-Off Day 2015?
• Upon death or drug discontinuation
• ODB At-home MedsCheck requirement
Directly observed therapy

• Written on the prescription
• Allows for safe dispensing until pain management/addiction program becomes available
  - 0.5 – 2 year waiting time
• Increases profit if nothing else
• Allows for more interaction and intervention with patient
  – Prepares patient for addiction treatment time commitment
Five minutes to make a difference

- Pharmacists CAN make a difference
- Respect, respect, respect
- Don’t judge ... care
- Change your ideas of success
- Methadone patients become friends of the pharmacy
- Valuable insight for patients’ activities of daily living
- Reward great behavior
Ask not why the addiction… but why the pain?