Opioid Analgesics: Best Practices for Prescribing, Dispensing, and Preventing Diversion

EDUCATIONAL OBJECTIVES

Upon completion of this activity, the participant should be able to:

1. Using data from West Virginia, DESCRIBE the epidemiology of chronic pain, demographics of patients who abuse opioids, addiction/abuse risk factors, and opioids’ abuse potential
2. DESCRIBE opioids’ characteristics (including toxicities and drug interactions) associated use disorders and behavioral responses to prescribed opioids
3. DESCRIBE best practices for prescribing of opioid analgesics and management of patients with pain
4. DISCUSS the complete range of legal requirements for controlled substance prescriptions, identification of fraudulent prescriptions, drug-seeking behaviors, and drug diversion
5. DESCRIBE risk reduction approaches, including FDA risk evaluation and mitigation strategies (REMS), and the West Virginia Controlled Substance Monitoring Program
6. Using a case study, APPLY best practices for opioid analgesics in ways that deal with known and potential abusers effectively, efficiently, and safely
7. EDUCATE patients on appropriate drug administration of naloxone rescue therapy and other overdose prevention strategies

Post-test/Rationale

1. Please select the statement about statistics that is TRUE:

   A. In WV, opioids were the leading cause of drug-related deaths, increasing 550% from 1999 to 2004 (largest state increase in the United States) and 214% from 2001 to 2010.***
   B. WV had the lowest age-adjusted rate of opioid-related deaths in 2012 and highest death rate involving prescription drugs in 2008.
   C. From 2009 to 2012, opioid exposure incidents reported to the WV Poison Control Center remained steady.
   D. Statistics mean the same things to clinicians and patients; most people just ignore them.

Correct Answer: A

Answer rationale: In WV, opioids were the leading cause of drug-related deaths, increasing 550% from 1999 to 2004 (largest state increase in the United States) and 214% from 2001 to 2010. WV also had the highest age-adjusted rate of opioid-related deaths in 2012 and highest death rate involving prescription drugs in 2008. From 2009 to 2012, opioid exposure incidents reported to the WV Poison Control Center increased by 12.5%. For health care professionals, statistics provide some evidence that the opioid problem is real, even if their source or accuracy is questioned. For patients, statistics have little meaning. They are more concerned about the reality of the problem—the addict in the family; the social, emotional and economic cost of continuing to abuse drugs; and the reality that abuse is risky.

2. Which of the following is NOT a change made in the current American Psychiatric Association’s Diagnostic and Statistical Manual (DSM) 2013?
A. It merged the criteria for “substance dependence” and “substance abuse.”
B. It eliminated physiologic dependence as a diagnostic criterion.
C. It refers to substance abuse and dependence as substance use disorder (SUD).
D. It ignores combined opioid abuse and dependence.***

Correct Answer: D
Answer rationale: Most clinicians use the American Psychiatric Association’s (APA’s) Diagnostic and Statistical Manual (DSM) to diagnose psychiatric conditions. Acknowledging that criteria used previously were prone to misinterpretation, the 2013 DSM-5 merged the criteria for “substance dependence” and “substance abuse.” The DSM-5 eliminated physiologic dependence as a diagnostic criterion. The DSM-V now refers to substance abuse and dependence as substance use disorder and combined opioid abuse and dependence as opioid use disorder, with severity of both measured on a continuum.

3. Select the statement that is TRUE about discontinuing long-term opioid therapy:
   A. All opioids doses are decreased in exactly the same way.
   B. Patients usually accept that they will experience pain.
   C. Prescribers should make decisions about tapering therapy on an individual basis.***
   D. A dose of 30 mg/day is a “magic number”; below 30 mg/day, patients can stop the opioid with no untoward effects.

Correct Answer: C
Answer rationale: When long-term opioid therapy is discontinued, specific steps should be followed to minimize the effects of withdrawal. Decreases in drug dosage should be managed as follows:
   - Methadone:
     - Decrease dose by 20%–50% per day until a dose of 30 mg/day is reached
     - Then decrease by 5 mg/day every 3–5 days to 10 mg/day
     - Then decrease by 2.5 mg/day every 3–5 days
   - Morphine sustained/controlled release/COR:
     - Decrease dose by 20%–50% per day to a dose of 45 mg/day
     - Then decrease by 15 mg/day every 2–5 days
   - Oxycodone controlled release:
     - Decrease dose by 20%–50% per day to a dose of 30 mg/day
     - Then decrease by 10 mg/day every 2–5 days

Some patients may have a great deal of anxiety about the potential for increased pain or experiencing withdrawal symptoms. In all cases, prescribers should make decisions about tapering therapy on an individual basis.

4. Which of the following is an appropriate way to protect pharmacy practices from becoming easy targets for drug diversion?
   A. Constant vigilance against forged or altered prescriptions***
   B. Dispensing controlled substances outside of the usual course of professional treatment
C. Using drug quantity and prescription filling frequency as the sole indications of improper prescribing
D. Advertising the availability of naloxone

Correct Answer: A
Answer rationale: Pharmacists have a professional responsibility to protect their practices from becoming easy targets for drug diversion. This starts with a constant vigilance against forged or altered prescriptions. The Controlled Substances Act holds pharmacists personally responsible for knowingly dispensing controlled substances outside of the usual course of professional treatment. Especially with regard to opioid prescribing for pain, prescribed drug quantity and prescription filling frequency should not be used as sole indications of improper prescribing or prescription fraud.

5. Three patients arrive in the pharmacy within several minutes of each other. They all have prescriptions for oxycodone written by the same prescriber whose office is at some distance from your location. Each of them also has prescriptions for benzodiazepines. What should you suspect?

A. These are forged prescriptions
B. This physician’s office has relocated
C. Your pharmacy’s advertising is effective
D. These prescriptions were not issued for a legitimate use

Correct Answer: D
Answer rationale: Indicators that a prescription was not issued for a legitimate medical purpose include the following:
• Prescriber writes significantly more prescriptions (or in larger quantities) than is normative for the region.
• Patient appears to return too frequently; a prescription that should last a month in legitimate use is refilled biweekly, weekly, or daily.
• Prescriber simultaneously writes prescriptions for drugs with opposite actions, such as CNS depressants and stimulants.
• Patient presents multiple prescriptions written for other people.
• Several people appear together or within a short period, producing similar prescriptions from the same physician.
• Several people who are not regular customers or community residents present with prescriptions from the same physician.

6. Select the statement that is FALSE about West Virginia’s PDMP/Controlled Substance Automated Prescription Program.

A. Nurses who administer opioid analgesics to patients must register with CSAPP.
B. Participants must update patient information in CSAPP at least annually.
C. Pharmacists must enter information into CSAPP within 24 hours pertaining to controlled substances dispensed to WV residents.
D. Before each patient search in CSAPP, pharmacists must certify that they will not allow access by unauthorized persons.

**Correct Answer: A**

Answer rationale: West Virginia’s prescription drug monitoring program (PDMP) is the Controlled Substance Automated Prescription Program (CSAPP). All clinicians who prescribe or dispense opioid analgesics to patients for chronic noncancer pain must register with CSAPP and obtain information on these patients at least annually. Prescribers and pharmacists must enter all information pertaining to controlled substances in Schedules II, III, or IV that are dispensed to WV residents into CSAPP within 24 hours. Before each patient search, prescribers and pharmacists must certify that they are seeking data solely for the purpose of providing health care to current patients, and that they will not allow access by unauthorized persons. PDMPs are available in almost every state. But underuse by pharmacists may have limited their efficacy.

7. A long-time pain management patient who is on worker’s compensation presents a prescription for OxyContin 40 mg daily, #28, written by a new physician and says he will pay cash for the prescription. He says he is still seeing his regular prescriber. What should you do?

A. Fill the prescription and allow him to pay cash
B. Fill the prescription and allow him to pay cash, but make a note of it on his profile
C. Fill the prescription but charge it to worker’s compensation
D. Tell Mr. Smith you need to ask his regular prescriber if it is acceptable to fill this prescription***

**Correct Answer: D**

Answer rationale: Filling the prescription and allowing the patient to pay cash is inappropriate. Instead, you should tell the patient you need to ask his regular prescriber if it is acceptable to fill this prescription. Collaboration between prescribers is needed to make sure everyone knows what the patient’s situation is.

8. Which of the following statements is TRUE?

A. Naloxone reverses the effects of benzodiazepines such as sedation, hypotension, and dysphoria.
B. Naloxone has no effect when given to people who have overdosed on agonist–antagonists such as pentazocine or buprenorphine.
C. Given to opioid-dependent patients, naloxone will produce withdrawal symptoms***
D. Naloxone’s actions last a few minutes following intranasal administration

**Correct Answer: C**

Answer rationale: Naloxone reverses opioids’ effects (e.g., analgesia, respiratory depression, sedation, hypotension, and dysphoria). Additionally, naloxone can reverse the psychotomimetic and dysphoric effects of agonist–antagonists (i.e., pentazocine or buprenorphine). When administered to patients who are dependent on opioids, naloxone will produce withdrawal symptoms (flushing, dizziness, tiredness, weakness, nervousness, restlessness, irritability, body
aches, diarrhea, stomach pain, nausea, fever, chills, piloerection [goosebumps], sneezing, shortness of breath, or runny nose) within minutes; these symptoms usually subside over approximately 2 hours. The severity and duration of withdrawal depends on the naloxone dose and the patient's opioid dependence type and severity. As naloxone’s effects wear off, patients may slip back into sedation depending on the duration of action of the opiate on which they overdosed.

9. A physician tapers Mrs. Young’s opioid dose to 30 mg daily over several weeks. She has no other changes to her regimen, and her laboratory tests and radiographs are unchanged. After 3 weeks at the 30 mg dose, Mrs. Young visits the local emergency department one evening and then presents a prescription for hydrocodone for breakthrough pain at your pharmacy. She says she will tell the doctor about this prescription when he sees him next week. Based on the facts presented here, which of the following is a possibility?

A. Pseudoaddiction***
B. Manipulation
C. Drug interactions
D. Opioid allergy

Correct Answer: A
Answer rationale: When patients visits the local emergency department after hours and receive opioid prescriptions for breakthrough pain, addiction may be a possibility, but it is also possible that the patient is exhibiting pseudoaddiction because the pain is unrelieved.

10. When a concerned bystander suspects an overdose and decides to administer naloxone, when should he or she call 911?

A. Before administering naloxone
B. Immediately after administering naloxone***
C. After administering 5 minutes of rescue breathing
D. Once the patient exhibits withdrawal symptoms

Correct Answer: B
Answer rationale:
- Bystanders should administer the naloxone, then call 911. They should then administer rescue breathing to prevent organ damage.
- Once bystanders call 911, ambulance dispatchers will usually coach them until help arrives.
- Naloxone works in 2 to 5 minutes depending on its method of administration; take-home methods generally work in 5 minutes; naloxone's effects last 30 to 60 minutes.
- The bystander must stay with the overdose victim until help arrives; additional doses of naloxone may be needed.
- Naloxone will not reverse overdoses from nonopioids drug, and will not harm someone of they are not taking opioids and it is given by mistake.
- Naloxone is safe for pregnant women.