

ROLE OF THE PHARMACIST IN OPIOID SUBSTITUTION THERAPY

OBJECTIVES

- ▶ Understand that community pharmacists are well positioned to make objective judgments of patient progress and possible relapse
- ▶ Appreciate that pharmacists are well situated to monitor attendance and adherence
- ▶ Increase understanding of the pharmacist's role in opioid substitution therapy and the management of dispensing issues

INTRODUCTION

- ▶ Pharmacists have an important role to play beyond dispensing and supervising dosing
- ▶ Because of frequent, often daily, contact with patients pharmacists are well positioned to:
 - monitor attendance and adherence
 - alert the treatment team to positive and negative changes in behaviour and to possible relapse
 - provide education and monitor drug therapy
 - positive impact on patient outcomes by encouraging and supporting the patient in their recovery

THE PHARMACIST'S ROLE

- ▶ To ensure that the Rx meets CPSS standards
- ▶ To provide patient-centered, individualized care
- ▶ To safely dispense the patient's medication
- ▶ To assess for clinical stability and progress in treatment

Methadone/Buprenorphine Prescription Requirements

- ▶ Includes the patient's name, address, DOB, health card number and the name and address of the prescriber
- ▶ Clear start and end date
- ▶ Dose written in numbers
- ▶ Days of the week for witnessed ingestion and carry doses specified
- ▶ "Daily witness unless pharmacy closed"
- ▶ Faxed and legible or sent electronically

Prescribers:

- ▶ If prescribing medication(s) to be dispensed with methadone or buprenorphine provide a dispensing interval
- ▶ Good practice to note any changes to the patient's dose or carry schedule

Pharmacists:

- ▶ NO doses should be dispensed after the end date of the Rx
- ▶ Any missed doses within the Rx start and end dates are not considered "owed" to the patient
- ▶ It is the pharmacist's responsibility to confirm the prescriber's methadone exemption
- ▶ Verify exemptions by calling the Office of Controlled Substances 1-866-358-0453

Provide Patient-Focused Care

- ▶ Recognize that patients experience social stigma, be non-judgmental, respectful
- ▶ Understand that patients may have:
 - concurrent disorders
 - histories of abuse, trauma, loss
 - low frustration tolerance, exaggerated panic response, poor planning and communication skills
 - inappropriate coping strategies such as aggression and escalation
 - legal, financial, housing, family and child welfare issues

Build Therapeutic Relationships

- ▶ Get to know each patient's strengths, weaknesses and personalities to note any changes in behaviour and self-care
- ▶ Be aware of community supports/resources
- ▶ Provide ongoing patient education
- ▶ Monitor for adverse effects, drug interactions
- ▶ Motivate and encourage:
 - congratulate successes
 - view relapse as a learning experience for the patient rather than as a failure

DISPENSING SHOULD BE DONE PRIVATELY AND DISCREETLY.

In an Ontario survey of methadone patients, 80% indicated that the most challenging issue for them at the pharmacy was a lack of privacy.

Dispense Safely

1. Identify the patient
 - ask for ID or keep patient photos on file
 - address the patient by name when dosing
 - have the patient confirm their dose and sign for it
2. Check for med changes/missed doses
 - review patient profile for med changes
 - check for missed doses: is it safe to dispense the prescribed dose?

Dispense Safely

3. Assess for intoxication
 - before medicating look for signs of intoxication, especially with CNS depressants
 - talk with the patient and ask them to remove sunglasses or obstructive clothing

Assess for Clinical Stability

- ▶ Pharmacists can assist prescribers in assessing patient progress and safety
- ▶ Notify prescribers about:
 - missed doses/patterns of missed doses
 - appropriateness of dose: communicate signs and/or patient reports of withdrawal or overmedication
 - patients presenting at the pharmacy intoxicated

Assess for Clinical Stability

- ▶ Communicate relevant observations about:
 - changes in patient behaviour or adherence
 - disruptive behaviour
 - deteriorations or improvement in patient self-care (hygiene, grooming, dress)
 - patient's ability to store carry doses safely
 - vomited doses, lost or stolen carries
 - early ingestion of take-home doses

DISPENSING ISSUES IN COMMUNITY PHARMACY

Vomited/Replacement Doses

- ▶ SCPP guidelines allow replacement of vomited doses if emesis is observed and the pharmacist "knows beyond a reasonable doubt that it's legitimate"
- ▶ If not observed, determine time of emesis after ingestion and consult prescriber
- ▶ For methadone:
 - if emesis is within 15 mins replace full dose
 - 16-30 minutes, replace ½ dose
 - > 30 mins, no replacement

- ▶ For buprenorphine:
 - if emesis occurs after the tablet has dissolved it will not affect absorption, reassure the patient
- ▶ Lost or stolen carry doses:
 - advise patient to report to police and obtain file number
 - inform prescriber/request Rx to replace
- ▶ A NEW Rx is required for ALL replacement doses
- ▶ All replacement doses are WITNESSED ingestion

Missed Doses

- ▶ Know the initiation, stabilization and maintenance dosing of methadone to ensure patient safety
- ▶ Be vigilant about missed doses during initiation (0-2 wks) as patients are at risk of overdose
- ▶ Determine the reason, assess for withdrawal symptoms and ask patient how they have maintained (street methadone? when and how much? other drug use?)

- ▶ Report concerns around poor attendance, especially when dose is being adjusted
- ▶ Contact prescriber for dosing/new Rx if:
 - methadone patient misses 3 or more consecutive days
 - daily witnessed buprenorphine patient misses > 6 consecutive days
- ▶ To restabilize the patient, a **TIMELY** response from the prescriber is needed

Intoxication

- ▶ Before dosing assess for signs of overmedication or intoxication
- ▶ Signs include: smell of alcohol, ataxia, slurred speech, drowsiness, unusual behaviour, anxiety/agitation
- ▶ If intoxication is suspected do **NOT** medicate
- ▶ Avoid being confrontational, respectfully explain that it would be unsafe to medicate at this time
- ▶ Advise against driving; if pharmacy hours allow, ask the patient to return later to be reassessed
- ▶ Document the incident and report to prescriber

Pharmacy Transfers

- ▶ **ALWAYS** confirm the amount and time of the last dose when a patient is:
 - transferring from one pharmacy to another
 - upon hospital admission and discharge
 - incarcerated and upon release
 - being courtesy or guest dosed
- ▶ Prevents double-dosing or missed dosing which can compromise patient safety

Courtesy or Guest Dosing

- ▶ Best practice:
 - contact guest pharmacy before faxing Rx
 - copy the Rx to the patient's home pharmacy
 - include contact info for prescriber/clinic and home and guest pharmacies
 - home and guest pharmacies should confirm last dose at start and end of courtesy dosing

Diversion

- ▶ Risk factors:
 - suicidal ideation or cognitive impairment
 - transient housing or homelessness
 - concurrent addiction to other drugs
- ▶ Minimizing diversion, witnessed methadone:
 - dilute dose in 100 mls of crystalline drink
 - observe ingestion of entire dose
 - have the patient speak after their dose
 - provide water for the patient to rinse after taking their methadone

Diversion

- ▶ Minimizing diversion, witnessed buprenorphine:
 - up to 10 mins for tablets to dissolve
 - first few mins are most important
 - discreetly check under the tongue 1–2 mins after dosing
 - once the tablet has dissolved into a pulpy mass, diversion is still possible but more difficult

Diversion – Carry Doses

- ▶ Signs of carry dose diversion may include:
 - deterioration in patient’s self-care
 - repeated reports of vomited, lost or stolen carries
 - changes in behaviour, verbal abuse
 - repeated requests for extensions of carries without witnessed doses
 - missing empty carry bottles or returning empty bottles without the labels intact
 - reports that patient is selling their carries or approaching others to buy or share carries

- ▶ SCPP guidelines: “a pharmacist may refuse to fill an Rx for a carry if there is concern for the safety of the patient or the safety of others is at risk”
- ▶ Suspected diversion should be reported to the prescriber
- ▶ Whenever possible, refusal to fill should be made in collaboration with the prescriber

Preventing Disruptive Behaviour

- ▶ Be clear about pharmacy rules and behaviour expectations, consider a pharmacy-patient treatment agreement
- ▶ Create a professional, consistent, respectful environment
- ▶ Educate pharmacy staff so they are aware that patients may have concurrent mental health issues and histories of trauma
- ▶ Reduce patient stress
- ▶ Acknowledge and respond to patient concerns

Managing Disruptive Behaviour

- ▶ Remain calm and try not to take the situation personally
- ▶ Model appropriate behaviour by being courteous and respectful
- ▶ If a situation is escalating, tell the patient exactly what kind of behaviour is needed from them

Ending the Pharmacist-Patient Relationship

- ▶ SCPP guidelines:
- ▶ THREATS – patient has threatened the safety or well being of a staff member, another patient or a pharmacy customer by written or oral action
- ▶ DISRUPTIVE BEHAVIOUR – consistently demands service ahead of others, disrespectful to staff members, other patients or customers, “bullies” staff or other patients
- ▶ VIOLENT BEHAVIOUR – patient has engaged in violent behaviour towards a staff member, a patient or another person

- ▶ ILLEGAL ACTIVITY – shoplifting, theft on premises, vandalism, dealing drugs
- ▶ DIVERSION – patients who sell, lend or give away their methadone or buprenorphine are considered to be trafficking in a controlled substance
- ▶ When terminating service to a patient the pharmacist should communicate the decision to the patient personally, and to their prescriber, providing the reasons for ending the relationship

CONCLUSION

- ▶ A collaborative approach and effective communication between members of the treatment team is key to patient safety and success in opioid substitution therapy
- ▶ Community pharmacists are important members of the treatment team
- ▶ In addition to ensuring patient safety when dispensing, their frequent contact with patients enables them to make objective judgments of patient progress and to alert the treatment team to changes in patient behaviour and possible relapse

CASE ONE: VOMITED DOSE

J.I. calls your pharmacy on Friday evening at 6:15. His addictions clinic is closed. Sounding upset, J.I. asks you for his methadone prescriber's phone number because he just vomited and wants a replacement dose. In talking with J.I. you determine that he vomited more than one hour after receiving his methadone. How do you respond?

CASE TWO: MISSED DOSES

L.V. is a methadone patient at your pharmacy with a history of poor attendance. She presents at your pharmacy on Saturday morning for her methadone dose. When you check her sign sheet, you determine that she has missed three consecutive days of methadone. You also note that she was recently in detox and was to receive her methadone at another pharmacy the 8 days prior to the three missed doses at your pharmacy. You call the other pharmacy to confirm her last dose and the pharmacist tells you that she missed the last day of her prescription there. L.V. has missed 4 consecutive days of methadone. How do you proceed?

REFERENCES

1. Opioid Agonist Maintenance Treatment: a pharmacist's guide to methadone and buprenorphine for opioid use disorder, Pearl Isaac, Eva Janacek, Anne Kalvik, Maria Zhang. Centre for Addiction and Mental Health, 2015
2. Guidelines for Participation in the Methadone Program for Saskatchewan Pharmacists, October 2001, updated September 2010
3. Methadone Maintenance Treatment: Recommendations for Enhancing Pharmacy Services, Pearl Isaac and Beth Sproule, for the working advisory panel. Centre for Addiction and Mental Health, 2009
4. Saskatchewan Guidelines and Standards for the Treatment of Opioid Addiction/Dependence, College of Physicians and Surgeons of Saskatchewan, January 2015