College of Psychiatric & Neurologic Pharmacists

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OPIOID USE DISORDERS:
Interventions for Community Pharmacists

http://cpnp.org/guideline/opioid

Background

Community pharmacists have the dual responsibility of providing safe and appropriate access to opioids, while also protecting the public from the hazards of misuse and abuse. The community pharmacist can do the following: collaborate with the prescriber to ensure opioid prescriptions are for a legitimate medical purpose in the usual course of professional treatment; perform pill counts; review the prescription monitoring program; enforce a policy of no early refills for controlled substances; hold the patient accountable to the treatment agreement; assist with monitoring severity of pain and functional status of the patient; and monitor for indicators of misuse, abuse, or diversion.

Talking to Your Patients about Substance Use Disorders

- Choose a quiet, private location to discuss patient history or treatment response.
- Use open-ended questions that require more than yes/no answers.
- Avoid stigmatizing/judging words, such as “addict”, “junkie”, “hooked”, or “narcotic”.
- Ask about alcohol or illicit substance use to obtain a complete medication history and make clinical recommendations. Collecting this information should be considered routine practice.
- Encourage the patient to use the same pharmacy for all prescriptions and get to know other local community pharmacists in order to develop rapport and resolve prescription fill issues.
- Keep in mind that drug-seeking behavior is generally indicative of untreated substance use disorder.
- Do not make clinical decisions based on staff hearsay.
- Do not avoid or refuse to fill without discussion to clarify concerns as this does not resolve potential diversion and can deny a patient access to a necessary medication.

Three-Step Process for Screening Opioid Prescriptions for Safe Use

Pharmacists can use a 3-step process when dispensing opioid prescriptions for all patients. Once inserted into normal workflow, it will only take a few extra minutes for each opioid prescription. This process can be applied to any controlled substance, not just opioids.

Step 1: Verify the prescription (receiving the prescription)

- Ensure that the formal requirements for content of a controlled substance have been met under federal and state laws.
- Substantiate that the prescription is within the prescriber’s scope of practice.
- Verify the identity of the patient or person presenting the prescription.
- Confirm birth date and address of the patient.

Step 2: Patient assessment (prescription processing)

- Check in with the patient about the condition for which they are taking the medications (i.e., pain symptoms), what medications they have tried in the past, and their current state of functioning.
- Check prescription drug monitoring program.
- Screen for potential misuse or the presence of a substance use disorder.

Red flags that might indicate misuse or presence of a substance use disorder include:

- Use of many pharmacies or doctors.
- Obtains prescriptions from providers outside of their scope of practice.
- Presents with prescriptions for unusual quantities or combinations of medications or very high dosages.
- Presents to the pharmacy intoxicated.

 Last Updated: July 2016. This publication is supported by the American Academy of Addiction Psychiatry under its prime grant from the Substance Abuse and Mental Health Services Administration.

- Pays in cash/will not use insurance coverage.
- Demands certain brands of medication.
- Requests frequent early refills.
- Fills only the controlled substance even though accompanied by other prescriptions.
- Makes frequent trips to the ER for pain medications.
- Frequently travels a long distance to obtain.

What should you do if you suspect the patient is misusing his or her prescription opioid? The prescription can be refused, and prescribers and prescription drug monitoring programs should be notified, when appropriate in your state. Before refusing a prescription, the pharmacist should attempt to obtain more information from the prescriber regarding its necessity. If you believe that the patient may have an opioid use disorder, the pharmacist is well positioned to interface with the patient, work with other health care providers, and offer resources for substance use disorder treatment referral (see "Develop a Local Resource List" section).

Step 3: Clarification of patient responsibility (prescription delivery)

Request identification of patient or person receiving medication, obtain signature to signify acceptance of responsibilities, and explain that failure to meet the responsibilities below may result in denial of future pain medications:

- Medication will be used exactly as directed by the prescriber.
- Medication will be stored in a discreet and secure place.
- Details about your prescription(s) will only be shared with caregiver or others who need to know.
- Alcohol and illicit drugs will not be used in combination with this medication.
- Medication will not be shared.
- Medications will not be filled prior to due date.

Improving the Health of Patients with Substance Use Disorders

Promote Naloxone Access

Pharmacists are in the optimal position to increase distribution of naloxone for those at risk for an opioid overdose. Most states have laws to make it easier for medical professionals to prescribe and dispense naloxone and for the layperson to administer without fear of legal repercussions.[3]

Some states allow pharmacists to dispense naloxone pursuant to standing order or collaborative practice agreement without a prescription. Watch the webinar "Putting Naloxone into Action" (https://cpnp.org/ed/university/course/putting-naloxone-action) to learn more about different models for naloxone distribution that can be implemented at your pharmacy.

The College of Psychiatric and Neurologic Pharmacists has published a Naloxone Access Guideline for Pharmacists (https://cpnp.org/guideline/naloxone), which reviews patient selection, formulations, storage, billing procedures, examples of successful models, and patient counseling points. This is a great resource for community pharmacists taking the next step toward developing a naloxone distribution plan in their practice setting.

Encourage Medication-Assisted Treatment (MAT)

MAT encompasses opioid agonist treatment and opioid antagonist treatment. Opioid agonist treatment is a life-saving intervention for opioid use disorders. Both methadone and buprenorphine can be prescribed to alleviate symptoms of opioid withdrawal, block opioid use, and allow the patient to begin to focus on improving their overall health. Relapse rates without medication-assisted treatment are substantial for opioid use disorder; therefore, long-term treatment may be the goal. Naltrexone is an opioid antagonist that has also been shown to be effective in reducing relapse.

Buprenorphine/naloxone

Buprenorphine/naloxone is the only opioid agonist medication in the United States that can be prescribed to treat opioid use disorder outside of an opioid treatment program (OTP). Specially trained physicians with DATA 2000 waivers, also known as "X numbers," are authorized to prescribe buprenorphine. The Comprehensive Addiction Recovery Act (CARA) expands prescribing to nurse practitioners and physicians assistants under specific circumstances. Buprenorphine/naloxone serves a critical role for patients unable to access OTP services, for those who do not respond well to methadone, and for patients who are better served in primary care, behavioral health, or other outpatient settings.

Patients presenting for initial prescriptions may be in acute opioid withdrawal and quite uncomfortable, therefore, it is necessary to have the medication in stock and readily available. The pharmacist should promptly assist with issues that might delay medication dispensing, such as insurance prior authorization. Naloxone is added to the formulation to prevent diversion. Other than pregnant women, most patients with opioid use disorder should be receiving prescriptions for the combination product. Buprenorphine/naloxone is available in multiple strengths and formulations. The pharmacist should be familiar with differences in formulations and dosing conversions, as well as manufacturer coupons, vouchers, or savings programs.

Unlike other maintenance medications, buprenorphine/naloxone may be prescribed in very limited quantities to ensure close follow up, particularly during the induction process. These frequent refills provide a high level of contact at the pharmacy and the opportunity for the pharmacist to actively participate in the patient's treatment. Concerns, progress, and missed doses should be clearly communicated with the physician. Some patients may require more intensive monitoring during which they receive only one dose per prescription. Providers may also request supervised dosing with which the patient takes the dose at the pharmacy window. This level of care can make a significant difference in keeping patients engaged in treatment and achieving remission from opioid use disorder. Buprenorphine/naloxone can also be prescribed within an OTP following the same procedures used for methadone dispensing.

Methadone

Methadone maintenance has been the standard of care for opioid use disorder in the United States since it was developed in the 1960s. Methadone for opioid use disorders can only be dispensed from OTPs, which provide a range of on-site services and are tightly regulated. Unlike methadone prescribed for pain, methadone maintenance is usually given once daily and is not reported to the state's prescription drug monitoring database.

OTPs are often concentrated in cities, which leaves many rural and suburban residents without ready access. For this purpose, the Federal government has developed guidelines to establish "medication units," which can be remote dispensaries of methadone maintenance. Medication units can be located in community or hospital pharmacies.

Pharmacists interested in developing medication units should review the Federal Guidelines for Opioid Treatment (available at http://store.samhsa.gov/shin/content//PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf) and state specific laws and regulations.

Naltrexone

Naltrexone is an opioid antagonist, which is available in oral and long-acting injectable formulations. Literature demonstrates that the long-acting injectable is more effective than placebo in preventing relapse. It is unclear when naltrexone should be prescribed versus opioid agonist treatment. A long-term comparison study is currently being completed. Because patients receiving naltrexone must be opioid-free for at least 7 to 10 days, there is an increased risk for opioid overdose prior to starting treatment. Patients should be appropriately educated and offered naloxone.

MAT Counseling Points

Buprenorphine/naloxone

- Sublingual tablet or film should be kept under the tongue until completely dissolved. Buprenorphine is not well absorbed orally. Swallowing will result in a reduction in dose/effect and may result in withdrawal symptoms.
- Buprenorphine/naloxone should not be initiated until the patient is experiencing mild to moderate opioid withdrawal symptoms. Starting the medication too early can induce opioid withdrawal.
- Combining this medication with other respiratory depressants, such as benzodiazepines, can increase the risk for overdose toxicity.

Naltrexone

- Wait at least 7 to 10 days after discontinuing opioids to prevent inducing opioid withdrawal. May have to wait up to 14 days after discontinuing long acting opioids (buprenorphine/methadone) to prevent withdrawal.
- Risk for overdose is increased during waiting period to initiate naltrexone as patient's opioid tolerance may be reduced.

Provide Access to Clean Needles

Considering the devastating effects of increases in injection drug use, hepatitis C, and HIV as well as the financial toll on health care costs, community pharmacies should consider selling syringes without regard to intended use in an effort to reduce rising rates of blood-borne disease transmission. Given the lack of options for people who inject drugs to access syringes from other sources, pharmacies play a critical role. The American Pharmacists Association supports nonprescription sale of syringes as a tool to reduce HIV and hepatitis C transmission and encourages state legislature and boards of pharmacy to adopt laws which support unrestricted syringe and needle sales within pharmacies as a public health service.

Developing a Local Resource List

A pharmacist is much more likely to make an intervention, if resources have already been identified and are readily available. Unfortunately, there is no central location for all pharmacists to identify buprenorphine prescribers or licensed OTPs. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a link on its website to identify buprenorphine prescribers. However, participation is voluntary, and a subset choose not to participate. The link should still be included in any resource document.

The pharmacist can spend a few minutes using the internet to identify local substance abuse treatment referral programs. For instance, your city or state may offer substance use and mental health crisis hotlines, which can provide patients with information on local services and treatment. Your county's public health website should include substance treatment resources. Patients can also be referred to their primary care physicians, employee assistance programs, self-help groups (such as 12-step), and/or health insurance companies. Family members may have questions about substance abuse.

The National Institute on Drug Abuse publishes a website that provides information on commonly abused drugs for the public. Creating a preprinted list of local and national resources can make providing a referral easier and timelier. (See "Resources" section for links.)

Helpful Resources

1. SAMHSA behaviors health treatment services locator (which includes substance use disorder treatment): National Helpline 1-800-662-HELP (4357), https://findtreatment.samhsa.gov/
2. SAMHSA buprenorphine treatment physician locator: http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator/
3. SAMHSA opioid treatment program directory: http://dpt2.samhsa.gov/treatment/directory.aspx
4. National Institute on Drug Abuse http://www.nida.nih.gov
5. Risk assessment tools http://www.opioidrisk.com/node/774
6. VIGIL helps pharmacists screen controlled substances https://www.pharmacist.com/vigil-helps-pharmacists-screen-controlled-substances
7. A pharmacist's corresponding responsibilities and red flags of diversion http://deachronicles.quarles.com/2013/08/a-pharmacists-obligation-corresponding-responsibility-and-red-flags-of-diversion/; http://www.deadiversion.usdoj.gov/pubs/brochures/pharmguide.htm
8. ER/LA opioid analgesics REMS: The extended-release and long-acting opioid analgesics risk evaluation and mitigation strategy http://www.er-la-opioidrems.com/IwgUI/rems/home.action

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Disclosures

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Opioid Therapies (5H79TI025595) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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