Prescription Review Program

2013/2014
Annual Report & Business Plan

Date Submitted: 28/08/2014

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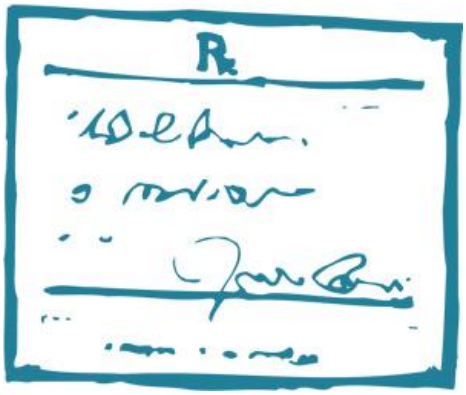


Annual Report 2013

The Prescription Review Program is an educationally based program of the College of Physicians and Surgeons that monitors for apparent inappropriate prescribing and apparent inappropriate use of PRP drugs that are included in regulatory Bylaw 18.1.

The Program alerts physicians of possible inappropriate prescribing or use of PRP drugs by their patients. The Program provides general information to physicians in order to encourage appropriate prescribing practices. In some cases, physicians are required to provide explanations for their prescribing of medications to which the Prescription Review Program applies. After reviewing a physician's reply, the Program will make recommendations, following best practices, to improve patient outcomes or reduce the possibility of misuse of these medications.

Alert letters include monthly computer generated double doctor letters to alert physicians if their patient has received a prescription of a PRP drug from three or more physicians. The reporting program cannot identify physicians working in the same clinic and seeing common patients, so the staff at the Program endeavors to identify these patients but are not always successful, resulting in some letters being sent to prescribers in the same clinic.

Alert letters are also sent to prescribers as a result of information received by the Program that an individual that has been prescribed PRP medications may possibly be misusing and/or diverting their medication. The Program does not suggest in those letters that the physician cease prescribing to the patient. Rather, the Program recommends that the physician put safeguards in place, such as treatment agreements, random urine drug testing or surprise tablet counts in order to prevent prescription drug misuse or diversion.

Other forms of alert letters include informing physicians of the requirements contained in College bylaws to write prescriptions for PRP drugs expressing concern about the legibility of prescriptions and letters to the College of Pharmacists to alert them to possible inappropriate dispensing of PRP drugs by pharmacists.

The program will send letters requiring physicians to explain their prescribing to a patient in situations such as:

- double doctoring for an extended period of time
- a pattern of early refills
- chronic use of benzodiazepines by a patient
- inappropriate use of PRP drugs as outlined by "The BEERS Criteria"
- prescribing of large quantities of immediate release opioids repeatedly without the use of a sustained release form
- prescribing of PRP drugs contraindicated for patients on the methadone program for addiction
- inappropriate chronic use of opioids known to have minimal analgesic effects combined with potential toxic metabolites or a high potential for developing dependency
- reports of illicit use of prescribed PRP drugs by reliable sources

After the physician provides an explanation, the Program can make appropriate recommendations to possible management changes by using information from national standards, guidelines, and sound medical practices (eg Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain).

In 2013, the Prescription Review Program continued to concentrate on awareness of the Canadian Guideline for the Safe and Effective use of Opioids for Chronic Non-Cancer Pain. By referring to and using this Guideline, physicians can have a comfort level in the prescribing of these drugs in order to provide optimal care to patients.

The PRP continues to monitor for the inappropriate chronic use of benzodiazepines, and in particular in the elderly. There continues to be a decrease in the use of these drugs as a hypnotic for the elderly since monitoring began in 2006. However, in the last two years this trend was reversed. We ask physicians to review the prescribing of these drugs to see if it is medically appropriate to wean patients from benzodiazepines or taper the dosages in order to minimize the risks of falls and other unwanted side effects that are common in the elderly from these medications. The Program will continue to focus on the chronic prescribing and use of benzodiazepines where it appears to be inappropriate to do so. The PRP will continue to provide physicians with the required information including safe tapering schedules.

The Prescription Review Program continues to receive more and more calls from physicians for assistance in appropriate prescribing of PRP medications to their patients. The PRP continues to be a reliable source of information for physicians located in rural isolated practice settings who ask for recommendations on the safe and effective use of PRP drugs for their patients.

On December 31, 2013, the Saskatchewan Drug Plan delisted meperidine (Demerol) and pentazocine (Talwin) as benefits. Physicians with patients on Demerol prior to December 31, 2013 have until June 30, 2014. There is a 6 month grandfather phase in order to provide physicians with enough time to determine alternate appropriate management plans.

In February 2012, the Prescription Review Program made a presentation at a National Dialogue on Prescription Drug misuse hosted by the Canadian Centre on Substance Abuse. As a result of that conference, a national advisory council was appointed that included the PRP as a member to develop a pan-Canadian approach to address prescription drug misuse. There are five streams of action with recommendations in prevention, education, treatment, surveillance and monitoring and enforcement.

On March 27, 2013 the Canadian Centre on Substance Abuse held a press conference releasing Canada's first National Prescription Drug Strategy, First Do No Harm: Responding to Canada's Prescription Drug Crisis. The next phase is the implementation process which is scheduled to occur over a 10-year period. For further information, please visit the website at www.ccsa.ca.

The Prescription Review Program thanks the physicians of Saskatchewan for their cooperation and assistance with this educationally directed process as demonstrated by the changes in the prescribing of PRP drugs.

Physicians are encouraged to contact the Prescription Review Program if they require recommendations in managing high risk patients using PRP drugs.

HIGHLIGHTS OF PRP ACTIVITIES FOR 2013

The summary of the day to day activities of the PRP can be illustrated as seen below.

Letter Count 2013	
Type of Letters	**# Letters Sent**
System Generated Double Doctor	6983
Explain/Alert	1205
Acknowledgement/Recommendations	736
Miscellaneous	223
Prescription	23
Pharmacy	67
Law Enforcement Formal Investigation	76
Coroner	28
Total	**9341**

System Generated Double Doctor – where patient received PRP meds from 3 or more physicians in a calendar month

Explain – letters where physicians are required to explain their prescribing; provide the medical indication and rationale for the particular medication

Alert – where the patient is identified as potentially misusing their meds

Acknowledgement/Recommendations – letters of recommendations to physicians as a result of their reply letter of prescribing

Prescription – letters to physicians regarding Bylaws 17.1 and 18.1 regarding legibility and PRP requirements for a valid prescription

Pharmacy – letters to the College of Pharmacists when there are concerns pertaining to the dispensing of PRP meds identified, as well as letters to the College of Dental Surgeons when there are concerns pertaining to the prescribing of PRP meds by dentists identified

The Methadone Program and Prescription Review Program facilitate quarterly meetings of the College's Opioid Advisory Committee meetings. This committee includes chronic pain specialist Dr. M. Opdahl, pharmacist representative Lori Postnikoff, SRNA representative, Donna Cooke, addictions specialists Dr. P. Butt (chair), Dr. B Fern and Dr. L .Lanoie, Dr. C. Johnson, the Methadone Program Manager Dr. M. Markentin plus College support staff Doug Spitzig, Laurie Van Der Woude and Meagan Fraser. This committee is responsible for not only the provincial Methadone Program but also implantation of the Canadian Guideline for the Safe and Effective Use of Opioids for Non-Cancer Pain. The PRP utilizes physician members of this committee for peer review and prescribing guidance when required.

The PRP met with and presented to various regional drug strategy/harm reduction committees on four occasions in 2013.

On May 8, 2013 Doug Spitzig made a presentation to the Saskatchewan Provincial Drug Strategy Committee at their annual conference in Swift Current.

On March 19, 2013 in Prince Albert and March 20, 2013 in Saskatoon, Doug presented at the Saskatchewan Members of the Canadian Committee Epidemiology Network on Drug Use (CCENDU). This organization is located at the Canadian Centre on Substance Abuse and is an early warning network on substance abuse that is Canada-wide in scope.

On September 7, 2013 Doug presented at the education session of the CPSS AGM.

The PRP met with law enforcement in various locations to develop collaborative initiatives in dealing with prescription drug misuse.

The PRP participated in the SIPPA program for internationally trained graduates on four dates in 2013.

Doug Spitzig participated in the annual faculty meeting at the Michael G. DeGroote National Pain Centre located at McMaster University on May 31, 2013. Doug participated as a member of the national faculty on the Canadian Prescribing Guideline for the Safe and Effective Use of Opioids at the National Pain Centre located at McMaster University.

Doug also presented at the 11th Annual Peter & Anna Zbeetnoff Memorial Drug Therapy Decision Making Conference in Regina on March 8, 2013 on managing chronic pain.

The PRP collaborates regularly with the College of Pharmacists mainly through Lori Postnikoff, field officer; to identify apparent inappropriate dispensing of PRP drugs as the Program has no authority to deal with concerns that PRP drugs may have been inappropriately dispensed.

On eight occasions, the PRP has met either in person or via teleconference with Sask Health and other stakeholders including the CPSS, College of Pharmacists of Saskatchewan, Saskatchewan Registered Nurses Association and the College of Dental Surgeons in formulating strategic plans for the future of the program including participation of each stakeholder with regards to the monitoring processes of each of these members.

Prior to the advent of nurse practitioners prescribing PRP medications, the PRP has met and worked with the SRNA in 2013. This involved seven meetings and the development of two full day educational sessions, one in Regina and one in Saskatoon, in order to prepare nurse practitioners for the safe and effective prescribing of PRP medications.

The PRP and Health Canada (NIHB) collaborated in four teleconferences in 2013 on issues of apparent misuse of prescription drugs by NIHB clients.

The National Advisory Council on Prescription Drug Misuse in partnership with the Canadian Centre on Substance Abuse, a comprehensive 10 year pan-Canadian strategy, First Do No Harm: Responding to Canada's Prescription Drug Crisis was released in March 2013. This involved the National Advisory Council meeting four times including a two day in-person session in February 2013. The strategy highlights the actions required to address the harm associated with the misuse of prescription drugs in Canada in the areas of prevention, education, treatment, monitoring and surveillance and enforcement. Doug is a member of the monitoring and surveillance implementation team which met on four occasions in the last half of 2013.

At the end of 2013 it is estimated that the PRP has reviewed over 300,000 individual patient profiles since the inception of the Prescription Review Program monitoring process in November of 2006.

In 2013, the PRP received 285 phone calls from physicians for information on how to effectively manage patients that are of high risk for misuse and minimize the potential for harm.

The PRP receives calls regularly from concerned patients on the prescribing of their PRP drugs. In 2013 more than 130 calls were managed by the Program. Questions were answered and explanations were provided to patients on strategies for safe and effective use of their PRP drugs. They are always encouraged to speak with their physician in follow up. The PRP also receives regular calls from patients and physicians for information on medicinal marihuana in regards to the protocols for use and prescribing.

In 2013 PRP received 141 reports of suspected traffickers and/or abusers of PRP drugs.

In 2013, the PRP completed 10 physician profile reviews and conducted 1 personal physician interview at the College of Physicians and Surgeons with the Deputy Registrar.

The PRP reviewed 28 coroner reports on methadone-related deaths in 2013.

In Jan 2013, NIHB stopped paying for brand name Ritalin, Tylenol #4 and its generic form. Reviews were completed for each, identifying 209 patients paying cash for Ritalin and 96 patients paying cash for Tylenol #4 or its generic form and an intervention process was undertaken to minimize the potential risk of harm.

The staffing at the PRP includes Meagan Fraser, administrative assistant for the PRP and the Methadone Program and Laurie Van Der Woude, PRP Co-coordinator whose duties include the development of reports as a result of prescribing and profile reviews as directed by Doug Spitzig, the Program Manager. This process maximizes the Program's ability in reviewing, generating explain letters and providing recommendations using the national standards and guidelines and best practices to physicians in order to assist them to safely and appropriately prescribe PRP drugs to their patients. The structure of the Program allows Doug to address and collaboratively develop programs with regional stakeholders on prescription drug misuse which also allows him to collaborate nationally on prescription drug misuse through the national drug strategy's First Do No Harm: Responding to Canada's Prescription Drug Crisis and its implementation. This will enable the PRP to continue providing the province with a quality prescription monitoring program that will improve health outcomes and decreasing overall healthcare costs for the province of Saskatchewan.

BUSINESS PLAN 2014

1) Continue to effectively mine the PRP database to detect drug prescribing and patient utilization patterns of concern. This will increase due to increased resources.

2) Verbal and written interaction with individual physicians to gain insight with respect to the rationale for their prescribing patterns and modifying those patterns through very focused education and guidance. This work will also increase due to increased resources.

3) Continue interactions with groups of physicians to raise awareness about prescribing patterns, particularly in communities which are inappropriate and/or unsafe. There are already six identified at the start of 2014.

4) Interactions and collaboration with law enforcement agencies to curtail the incidence of diversion of PRP drugs on the streets and to identify individuals with addictions and steer them through a medical model for treatment of addiction rather than proceed through the judicial system. Utilizing the justice system to try to address addiction has proved to be financially expensive and has not resulted in positive health outcomes. This will be based on the Moose Jaw model that has proven to be efficient and cost effective. A presentation of this collaboration was presented to a national dialogue conference in Ottawa hosted by the Canadian Centre on Substance Abuse attended by fifty experts from across Canada.

5) Interactions with drug strategy committees at local and provincial meetings, including presentations on how to develop “made in local community solutions” to prescription drug misuse. This includes RHA’s and other agencies optimizing these strategies for harm reduction in their community including optimizing addiction support services.

6) Continue to participate as a member of a pan-Canadian committee in the development of a national strategy on prescription drug misuse in Canada under the direction of the Canadian Centre on Substance Abuse.

7) Work with E-Health in ensuring accuracy of PRP data and to look at expanding the parameters of the reporting system to identify inappropriate prescribing and use of PRP drugs for targeted populations such as the elderly.

8) The PRP will continue to focus on the inappropriate prescribing and use of benzodiazepines as there still appears to be a significant inappropriate chronic use of this family of drugs.

9) Organize and develop workshops targeted towards physicians practising in ER locations as apparent inappropriate prescribing resulting in prescription drug misuse has been identified. This was on the 2013 plan, but time and resources did not allow this to occur.

10) Continue presenting workshops in regional areas to promote the use of the Canadian Prescribing Guideline for the Safe and Effective Use of Opioids for Non-Cancer Pain. Misuse of opioids continues to be a major challenge of the PRP.

11) Continue to work collaboratively with The College of Pharmacists to aid them in creating a program for their members in the safe and appropriate dispensing and use of PRP drugs to improve health outcomes.

12) Continue to liaise with other agencies such as law enforcement in identifying new prescription drugs that are being misused which are not currently monitored by the PRP.

13) Establish a MOU with the Coroner's Office of Saskatchewan to be able to use information on deaths as a result of PRP drug overdoses to develop an approach on the prevention of the reoccurrence in the future following all the pertinent privacy legislation. Generally this can help also in assessing the effectiveness of the PRP as a result of interventions and recommendations. This is one of the recommendations of the National Drug Misuse Strategy. This was on the 2013 plan, but time and resources did not allow this to occur.

14) Develop and maintain a PRP location on the new CPSS website for general information and educational purposes, including resources required for safe and effective prescribing and use of PRP drugs.

15) Continue to work closely with the Methadone Program to ensure appropriate prescribing and use of methadone and other PRP drugs for those individuals on the Methadone Program.

16) Organize and facilitate four meetings of Opioid Advisory Committee at the College to address issues for the appropriate prescribing of opioids by physicians.

17) In 2014, the PRP will start the monitoring process for nurse practitioners. Once the monitoring report program is updated in order to capture the prescribing by NPs, they will then be permitted to prescribe by their regulatory body, the SRNA. At that point, NPs will be sent alert letters of double doctoring and reports of misuse. The SRNA will be alerted to potential inappropriate prescribing of NPs and PRP will assist on a consulting basis on the intervention processes that the SRNA may want to undertake as a result of the monitoring processes.

Appendix A: Demerol

Demerol 50 mg Nov 2006/2010/2011/2012/2013				
2006 Total Mg	**2010 Total Mg**	**2011 Total Mg**	**2012 Total Mg**	**2013 Total Mg**
2,409,200	2,107,000	1,746,850	1,417,700	1,018,500

% Change 2006/2010	% Change 2006/2011	% Change 2010/2011	% Change 2011/2012	% Change 2012/2013	% Change 2006-2013
-12.5 %	-27.5 %	-17.1%	-18.8%	-28.2	-57.7%

Demerol (500 tabs or greater prescribed for the month)	Date	# Drs Total Prescribed	#Targeted Drs **	% of Drs	Total # tabs	# tabs Targeted Drs	% tabs prescribed (Targeted Drs)	Total # patients	Total # pts (Targeted Drs)	% of pts (Targeted Drs)
	Sep 1-30 2010	278	16	5.8	42,958	10,589	24.6	473	83	17.5
	Sep 1-30 2011	256	16	6.3	35,673	10,713	30.0	431	87	20.2
	Sep 1-30 2012	228	9	3.9	28,354	5,558	19.6	353	36	10.2
	Sep 1-30 2013	188	3	1.6	22,884	1,946	8.5	275	11	4.0

** Targeted Drs – The number of doctors that prescribed Demerol with a total of 500 tablets or greater in that given month.

2012-2013 Changes

Doctors Prescribed decreased 17.5%
Targeted Doctors decreased 67%
% Doctors > 500 decreased 2.3%
Total # Tabs decreased 19.3%
Tabs from Targeted Doctors decreased 65%
Targeted Doctors % of Tabs Prescribed decreased 11.1%
Total # Patients decreased 22.1%
Total # Patients of Targeted Doctors decreased 69.4%
% of Patients of Targeted Doctors decreased 6.2%

Appendix B: Talwin

Talwin 50 mg Nov 2006/2010/2011				
2006 Total Mg	**2010 Total Mg**	**2011 Total Mg**	**2012 Total Mg**	**2013 Total Mg**
553,750	340,450	270,000	245,900	215,900

% Change 2006/2010	% Change 2006/2011	% Change 2006/2012	% Change 2006/2013	% Change 2010/2011	% Change 2011/2012	% Change 2012/2013
-38.5%	-51.2%	-55.6%	-61%	-20.7%	-8.9%	-12.2%

Appendix C: Fiorinal

Fiorinal Sep 2008/2010/2012/2013				
	2008	**2010**	**2012**	**2013**
Total # caps	9,730	4,616	5,088	3,140
Total # patients	105	58	66	45

% Change 2008/2010	**% Change 2010/2012**	**% Change 2008/2012**	**% Change 2008/2013**	**% Change 2012/2013**
-53% (5,114 caps)	10% (472 caps)	-48% (4,642 caps)	-67.6% (6, 590 caps)	-38.3% (1,948 caps)
-45% (47 pts)	14% (8pts)	-37% (39 pts)	-57.1% (60 pts)	-31.8% (21 pts)

Appendix D: Oxycodone

Oxycodone Oct 1 – 31 2006/2011/2012/2013						
	2006 Total Mg	**2011 Total Mg**	**2012 Total Mg**	**2013 Total Mg**	**% Change 2011/2012**	**% Change 2012/2013**
5mg IR	135,295	119,715	57,260	64,745		
10mg IR	284,240	369,530	243,880	209,280		
20mg IR	209,760	394,000	313,400	293,380		
Total IR	**629,295**	**883,245**	**614,540**	**567,405**	**-30%**	**-7.7%**
		(2006/2011) 40%	**(2006/2012) -2%**	**(2006/2013) -9.8%**		
5 mg SR	11,020	30,150	120	0		
10mg SR	399,340	361,800	301,340	255,790		
15mg SR			56,535	40,140		
20mg SR	848,160	1,016,760	704,440	615,280		
30mg SR			171,780	200,850		
40mg SR	906,320	1,107,640	757,600	647,240		
60mg SR			294,420	267,540		
80mg SR	543,520	1,100,720	783,120	623,120		
Total SR	**2,708,360**	**3,617,070**	**3,069,355**	**2,649,960**	**-15%**	**-13.7%**
		(2006/2011) 33.6%	**(2006/2012) 13.3%**	**(2006/2013) -2.2%**		
Grand Total	**3,337,655**	**4,500,315**	**3,683,895**	**3,217,365**	**-18%**	**-12.7%**
Grand Total % Change		**(2006/2011) 34.8%**	**(2006/2012) 10.4%**	**(2006/2013) -3.6%**		

	2006 Total Mg	**2011 Total Mg**	**2012 Total Mg**	**2013 Total Mg**	**% Change 2012/2013**
Oxycodone I/R	629,295	883,245	614,540	567,405	-7.7%
Oxycodone S/R	2,708,360	3,617,070	3,069,355	2,649,960	-13.7%
Total	**3,337,655**	**4,500,315**	**3,683,895**	**3,217,365**	**-12.7%**
Total % Change		**(2006/2011) 34%**	**(2006/2012) 13%**	**(2006/2013) -3.6%**	

Appendix E: Hydromorphone, Morphine and Oxycodone

Hydromorphone, Morphine and Oxycodone Jan 1 - Mar 31 2011/2012/2013				
	2011 Total Mg	**2012 Total Mg**	**2013 Total Mg**	**% Change 2012/2013**
Hydromorphone I/R	3,957,207	4,068,978	4,359,431	7.1%
Hydromorphone S/R	6,719,322	7,191,042	8,069,142	12.2%
Total Hydromorphone	**10,676,529**	**11,260,020**	**12,428,573**	**10.4%**
Morphine I/R	3,617,840	3,772,305	4,060,410	7.6 %
Morphine S/R	11,896,425	11,297,105	10,090,275	-10.7%
Total Morphine	**15,514,265**	**15,069,410**	**14,150,685**	**-6.1%**
Oxycodone I/R	2,103,700	1,927,535	1,609,260	-16.5 %
Oxycodone S/R	10,536,835	9,813,420	8,178,810	-16.6%
Total Oxycodone	**12,640,535**	**11,740,955**	**9,788,070**	**-16.6%**

Morphine Mg Equivalent Jan 1 – Mar 31 2011/2012/2013			
	2011	**2012**	**2013**
Hydromorphone IR	19,786,035	20,344,890	21,797,155
Hydromorphone SR	33,596,610	35,955,210	40,345,710
Total IR & SR	**53,382,645**	**56,300,100**	**62,142,865**
Morphine IR	3,617,840	3,772,305	4,060,410
Morphine SR	11,896,425	11,297,105	10,090,275
Total IR & SR	**15,514,265**	**15,069,410**	**14,150,685**
Oxycodone IR	3,155,550	3,013,508	2,413,890
Oxycodone SR	15,805,252	14,720,130	12,268,215
Total IR & SR	**18,960,802**	**17,733,638**	**14,682,105**
Grand Total	**87,857,712**	**89,103,148**	**90,975,655**
Grand Total % Change	**(2011/2013) 3.5%**	**(2011/2012) 1.4%**	**(2012/2013) 2.1%**

Morphine Mg Equivalent Jan 1 – Dec 31 2012/2013			
	2012	**2013**	**% Change**
Oxycodone	65,632, 957	57,395,647	-12.6%
Hydromorphone	240,218,905	255,847,680	6.5%
Morphine	62,101,245	47,869,668	-22.9%
Total	**367,953,107**	**361,112,995**	**-1.9%**

Population of SK	
2011	1,033,381
2013 (est)	1,114,170
Population Change	**(2011/2013) 7.8%**

Appendix F: Benzodiazepines

Benzodiazepines March 2011/2012/2013				
	2011 Total Mg	**2012 Total Mg**	**2013 Total Mg**	**% Change 2012/2013**
Alprazolam	42,385	31,310	30,684	-0.8%
Clonazepam	181,786	163,701	176,545	7.8%
Diazepam	552,577	453,207	464,729	2.5%
Flurazepam	121,995	66,480	63,525	-4.4%
Lorazepam	380,611	270,531	269,025	-0.6%
Oxazepam	708,165	597,725	606,025	1.5%
Temazepam	3,352,725	2,704,185	2,743,455	1.5%
Triazolam	22	1,239	1,252	1.6%

Benzodiazepines Mg Diazepam Equivalent March 2011/2012/2013			
	2011	**2012**	**2013**
Alprazolam	423,860	309,390	306,840
Clonazepam	3,635,740	3,273,980	3,530,900
Diazepam	552,577	453,207	464,729
Flurazepam	40,665	22,160	21,175
Lorazepam	1,903,060	1,352,670	1,345,125
Oxazepam	236,055	199,112	202,008
Temazepam	1,117,575	901,395	914,485
Triazolam	460	24,640	25,040
Total	**7,909,992**	**6,536,554**	**6,810,302**
Total % Change	**(2011/2013) -13.9%**	**(2011/2012) -17.4%**	**(2012/2013) 4.2%**

% Change 2010/2011	**% Change 2011/2012**	**% Change 2012/2013**	**% Change 2010/2013**
0.2%	-17.4%	4.2%	-13.7%

Appendix G: Methylphenidate

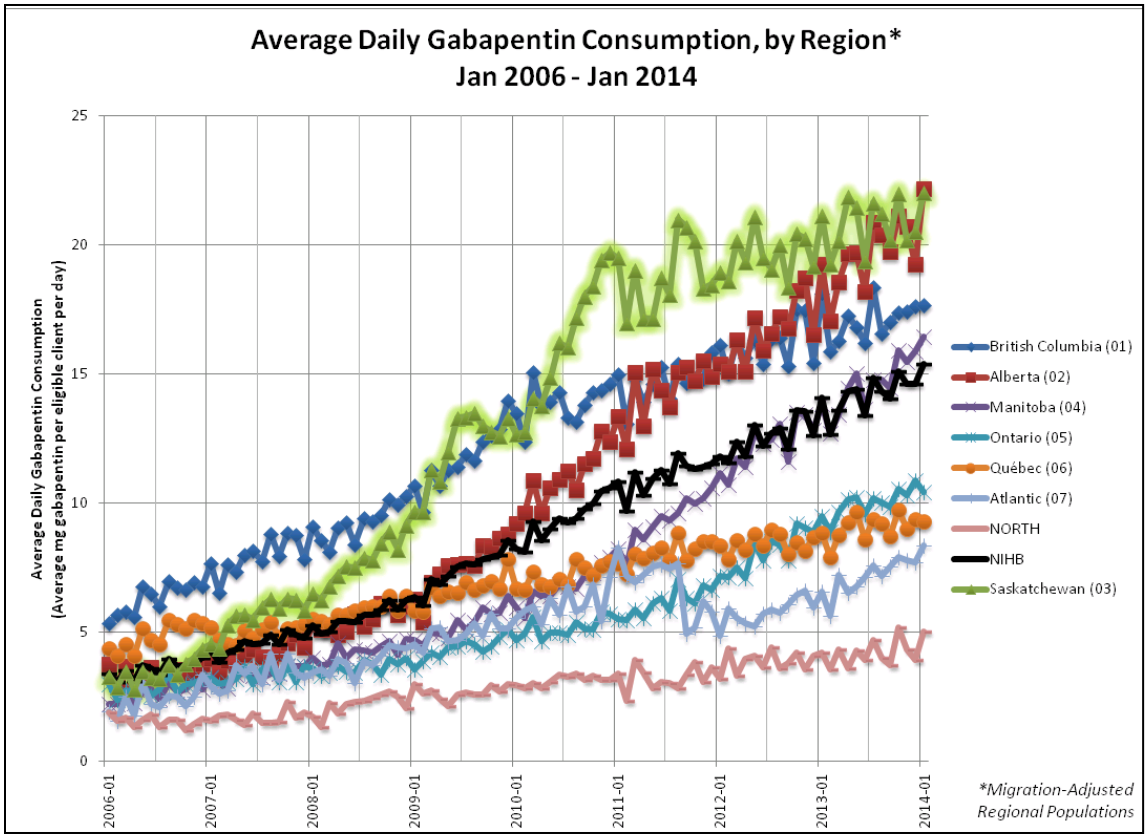
Methylphenidate May 2007/2012/2013				
	2007 Total Mg	**2012 Total Mg**	**2013 Total Mg**	**% Change 2012/2013**
IR	1,722,350	1,219,455	1,094,055	-10.3%
SR	2,234,160	1,000,200	871,180	-12.9%
Total IR & SR	**3,956,510**	**2,219,655**	**1,965,235**	**-11.5%**
Concerta	1,120,842	4,991,085	5,247,648	5.1%

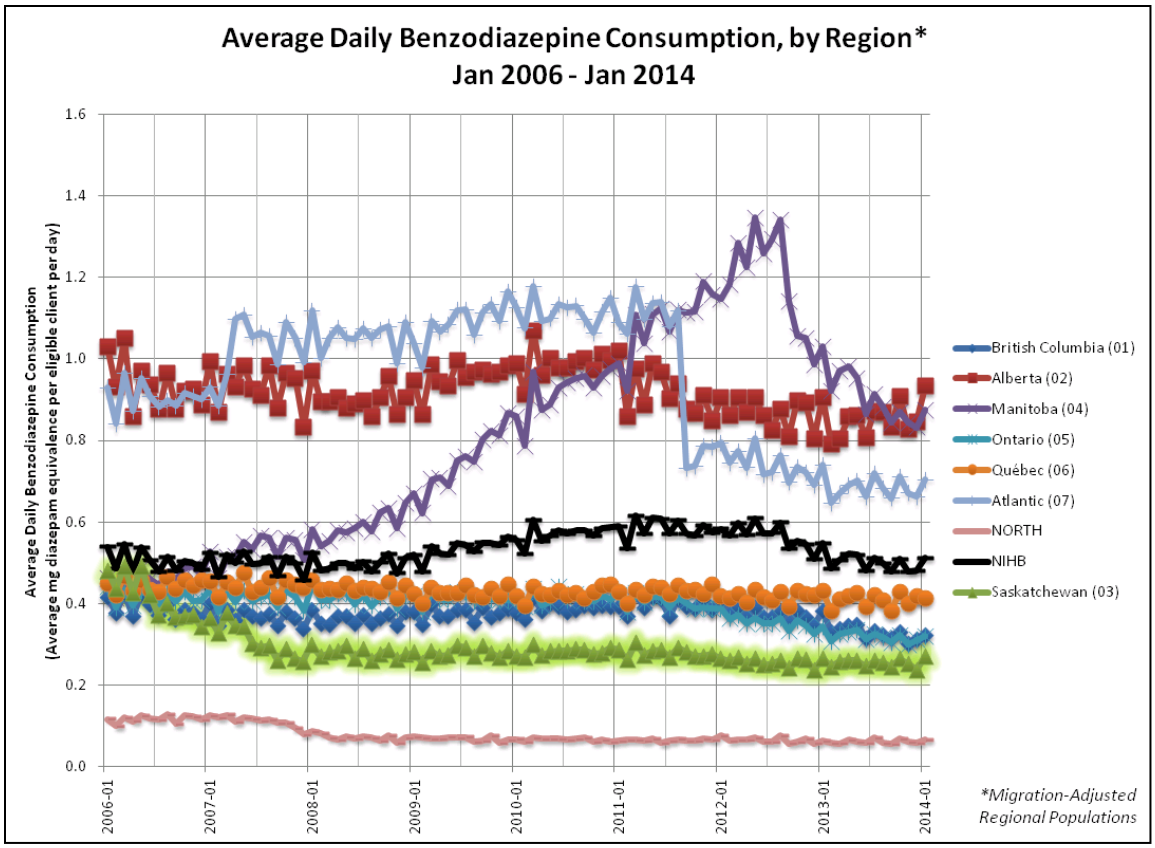
Appendix H: Interpretation of Drug Use Statistics

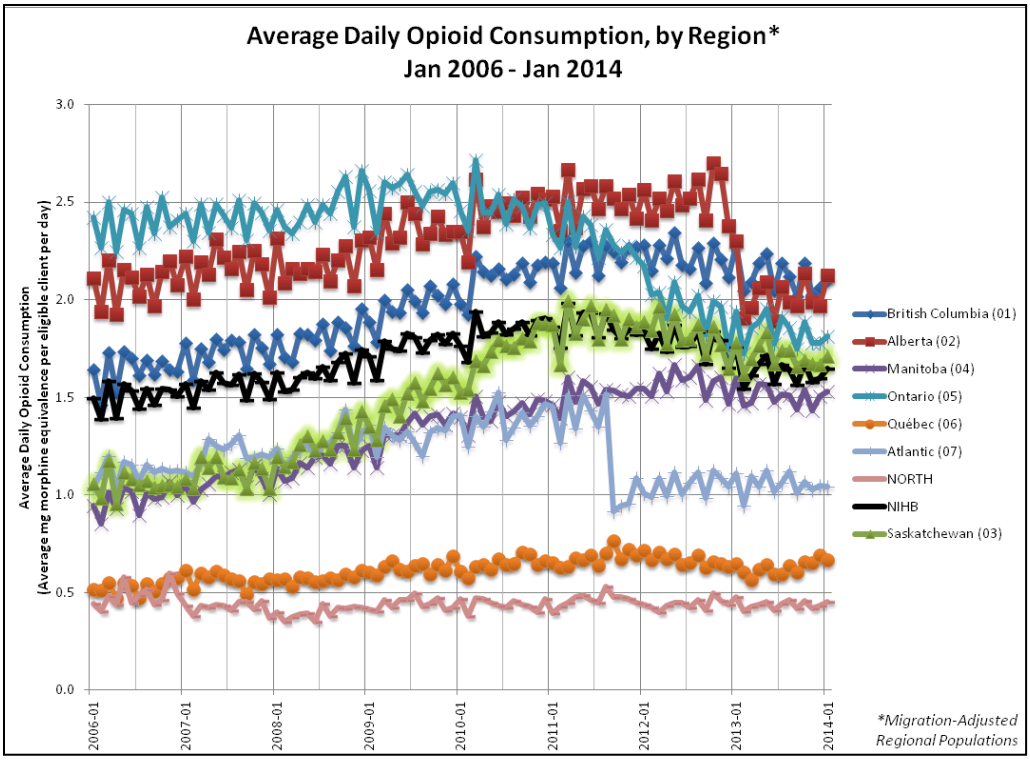
- There continues to be a significant decrease in the prescribing of both oral meperidine and Pentazocine.
- Both oxycodone and oral morphine show decreases in prescribing over the previous year.
- Hydromorphone continues to have increases higher than would be expected and has been identified as one of the principal drugs of choice for opioid misuse in Saskatchewan.
- The annual 2013 morphine mg. equivalents showed a decrease of 1.9% for morphine, hydromorphone and oxycodone combined.
- Benzodiazepines overall continue to show a decrease in prescribing with this being an area to be refocused on in 2013. (5 benzos increased; 3 benzos decreased)

This is only a representative portion of statistics that are kept by the PRP on trends of the prescribing of PRP drugs and will be helpful for the Program in planning activities for the next fiscal year.

Appendix I: NIHB Charts







* Charts provided by NIHB

Appendix I: Budget

Saskatchewan Prescription Review Program

Budget

	2012	2012	2013	2013	**2014**
INCOME (contributions):					
College of Physicians and Surgeons	12,000	12,000	12,000	12,000	12,000
Saskatchewan College of Pharmacists	6,295	6,367	6,367	6,367	6,367
College of Dental Surgeons	5,400	5,400	5,400	5,400	5,400
Saskatchewan Health	51,744	52,000	52,333	52,333	52,966
Other Ministry of Health Funding	0	0	178,660	215,286	221,647
Registration for Educational Sessions	0	0	0	0	0
Prescribing Course Rebate		0	0	0	0
Other income (interest)	1,000	1,460	1,000	235	1,000
Total Income (contributions)	**76,439**	**77,227**	**255,760**	**291,621**	**299,380**
EXPENDITURES:					
Accounting & Audit	3,300	3,688	3,200	3,803	3,700
Educational Sessions	0	0	8,000	0	8,000
Parking	7,560	6,360	6,500	5,917	6,500
Bank Charges	50	50	50	0	50
C.P.P.	5,760	5,520	5,729	5,719	5,900
CMA Pension Plan	10,416	21,304	21,299	22,559	21,900
Dental & Health Plan	18,310	15,168	18,021	14,128	15,168
Disability Income Plan	2,894	1,755	1,398	1,421	1,755
Employment Insurance	2,936	2,815	3,118	3,107	3,180
Group Insurance	585	669	637	737	669
Meeting Expenses	2,000	7,283	7,000	1,997	7,000
Office Automation	2,500	4,928	4,800	8,838	4,928
Office Equipment	3,800	3,742	4,000	3,019	4,000
Postage	2,800	3,769	3,100	3,191	3,700
Printing & Stationery	500	1,406	900	1,090	1,400
Salaries	184,821	187,198	196,603	201,140	203,830
Staff Development	400	0	400	1,337	400
Sundry	800	689	500	550	500
Office Supplies	2,400	2,450	3,400	2,411	3,400
Telephone & Fax	3,600	3,305	3,400	3,369	3,400
Total Expenditures:	255,432	272,099	292,055	284,333	299,380
Excess(deficiency) of Income over Expenditures absorbed by CPSS					
Excess(deficiency) of Income over	-178,993	-194,872	-36,295	7,288	0

Appendix J: Audited Financial Statements 2013

Please find enclosed a copy of the financial statements of the Saskatchewan Prescription Review Program for the year ended December 31, 2013.