unScripted

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PRESCRIPTION REVIEW PROGRAM
education | collaboration

OATP Opioid Agonist Therapy Program

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The PRP and OATP are programs administered by the College of Physicians and Surgeons of Saskatchewan.

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Welcome to *UnScripted*!

In January 2021, when the College of Physicians and Surgeons of Saskatchewan's *DocTalk* newsletter format was revised, Council suggested that the Prescription Review Program (PRP) and Opioid Agonist Therapy Program (OATP) should have a separate newsletter. Fast forward to 2022 and here we are!

Bi-annually, we hope to provide you with updates to our programs, practice guidance and case discussions regarding some tricky prescribing scenarios.

You may recall that the Provincial Auditor published an analysis of the PRP in 2019. Since then, here is some of the progress that we've made:

- **Regular review of the list of opioids drugs associated with misuse and substance use disorder**
  - CPSS Regulatory Bylaw 18.1 was amended to include monitoring of oxybutynin, baclofen, codeine (to include exempted codeine products), remifentanil, sufentanil, tramadol, diacetylmorphine, zopiclone, zolpidem, ketamine, diphenoxylate, tapentadol, pregabalin and lemborexant.
  - CPSS Regulatory Bylaw 18.1 was amended to include all "salts and enantiomers" of the panel of drugs.
- **Risk-based approach to identify concerns for opioid dispensing in Saskatchewan pharmacies**
  - Evidence-based parameters have been developed to assess prescribing and dispensing of PRP medications.
  - A specific pharmacy dispensing report was developed, enabling analytics for the Saskatchewan College of Pharmacy Professionals (SCPP), as requested.
  - We were involved with the content and editing of a module for SCPP/ Continuing Professional Development for Pharmacy Professionals (CPDPP) Harm Reduction Opioid Agonist Therapy Course.
- **Consider requiring physicians to review medication profiles prior to prescribing opioids**
  - Please see POLICY: Prescribing: Access to the Pharmaceutical Information Program (PIP) or electronic Health Record (eHR) Viewer

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- **Track the number of assessments, including the nature of assessments (including referrals to health care professional regulatory bodies)**
  - All correspondences are tracked and statistics are regularly generated
- **Only half of physicians who were sent Explain letters in 2018 received a response**
  - 90% of the 2019 Explain letters were responded to (in addition to the 150 backlog)
  - 90% of the 2020 Explain letters were responded to
  - Note: a small yearly discrepancy is expected due to letter flow into subsequent year.

Further recommendations specific to the Ministry of Health were reported in the Auditor's follow-up report.

We are excited to launch our newsletter! If you would like to write an article and/or have any ideas for topics that you and your colleagues might be interested in, please let us know.

Standards & Guidelines Update

After extensive consultation with stakeholders and opioid agonist therapy (OAT) providers, the Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder have been updated!

Drug Spotlight: PREGABALIN

Gabapentinoids (gabapentin and pregabalin), commonly prescribed in neurology, psychiatry and primary health, have great potential for misuse. At high doses, these medications can provide dissociative/psychedelic effects. Pregabalin can also be used to manage opioid withdrawal.

Pregabalin is dosed lower than gabapentin because its potency is six times greater than that of gabapentin. While the recommended maximum dosing differs depending on the indication, for adults, the dose should not exceed 600mg/day. Currently, the highest prescribed daily dose in Saskatchewan is 1200mg.

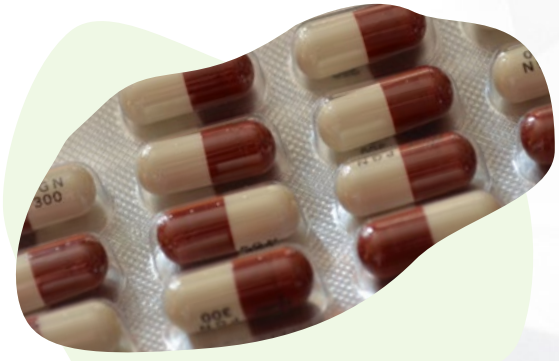
Pregabalin was added to bylaw 18.1 after it was identified as high-risk by numerous Saskatchewan OAT providers.

Suggestions for Prescribers:

- Be aware of the risks for misuse (it's happening in Saskatchewan!) as well as discontinuation symptoms (often similar to benzodiazepine/alcohol withdrawal)
- Evaluate the patient's history of medication misuse
- Identify early signs of potential misuse (e.g. requests for early releases, lost/stolen medication, visiting multiple providers)
- Provide assistance with tapering, when appropriate (co-occurring disorders such as opioid/benzodiazepine/alcohol use disorder may need to be considered as well)
- Manage risks associated with concurrent prescribing/illicit use

Reference:

Schifano, F. Misuse and Abuse of Pregabalin and Gabapentin: Cause for Concern?. CNS Drugs 28, 491–496 (2014). https://doi.org/10.1007/s40263-014-0164-4



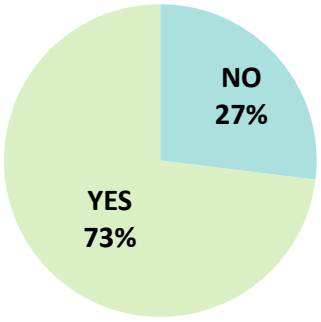
From the Frontlines

Saskatchewan Physicians Speak Up

The Council of the College of Physicians and Surgeons of Saskatchewn (CPSS) has been tasked with the following question as part of the strategic plan:

Should a safe opioid prescribing course be required for all licensed physicians?

We asked all Saskatchewan physicians the same question and here are the results to date from 208 respondents.



"As an OAT prescriber, I witness too many patients being mis-prescribed opioids and being prescribed into dependency."
– Survey comment

A Newly-Approved SK OAT Physician Reflects

Summarized, with permission

To be honest, our requirements are quite easy to complete. In my opinion, one of the biggest barriers is lack of comfort level with addiction care.

Speaking from experience, I was very intimidated to start prescribing OAT after residency and I spent much more time in clinic than what was required for OAT authorization. This is a huge area of practice to know/understand and I wouldn't expect anyone to be comfortable after an online course and 2 in-clinic days. I 100% agree that mentorship is extremely beneficial and it was a significant reason why I felt comfortable running my first few clinics. For those with fears, perhaps "joint clinics" where another physician in the clinic is available for any questions/concerns for the first month may be helpful.

While no one can argue that addiction work can be very challenging at times, I can honestly say my most rewarding moments in my career so far have been with OAT. Trying to get that message across is very important.

What's required to become an opioid agonist therapy provider for the treatment of opioid use disorder?

To be able to <u>initiate</u> therapy (eg. start therapy, change doses)

1. Completion of a workshop/course (many options, including in-person and online) – time commitment is dependent on the selected course but typically ranges from about 4-12 hours
2. Direct training (some prefer shadowing at a clinic while others prefer the CPSS-approved virtual case review – choose based on what works best for you) – time commitment is dependent on your mentor's assessment of competency but with some prep work in advance, the virtual case review usually only takes about 2.5 hours
3. Ongoing association with a mentor – consider this a "call a friend" option in case you have any questions in your first 2 years as an OAT provider
4. Continuing medical education (as expected for any practice)

To be able to <u>maintain</u> therapy (e.g. patient has been initiated and stabilized on OAT and transfers to you)

1. Completion of a workshop/course (as above)
2. Ongoing association with an Initiating Prescriber who resumes care if the patient destabilizes

Contact us and we will gladly assist with the approval process!

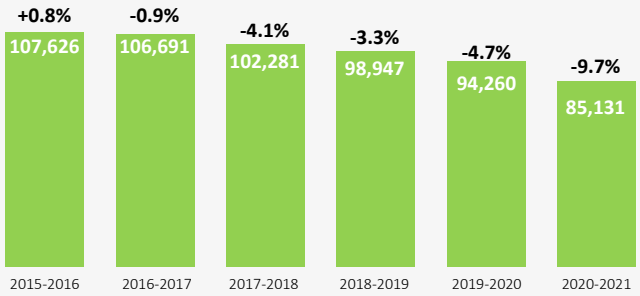
You can always start as a maintenance provider and transition to an initiating provider down the road.

Clarification regarding chart audits…

The OATP conducts educational chart audits. The intent is to provide you with feedback so that you can be confident you are meeting the expected standards. It's not that scary… really! We want to help! We even request a chart for a patient you might be struggling with to see if we can provide guidance/support.

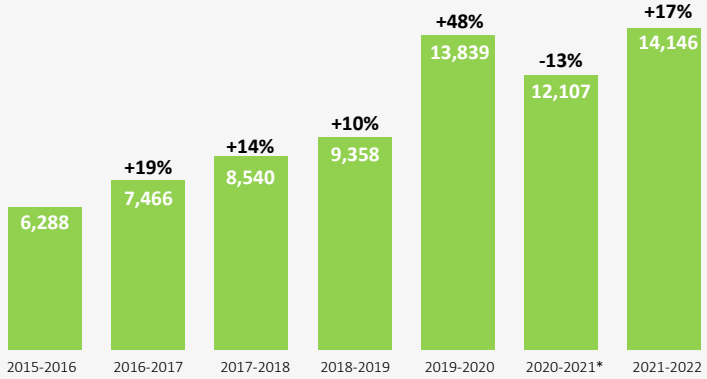
Opioid Prescribing Trends in Saskatchewan

SK Residents who received an opioid prescription (OAT claims excluded)



Above data provided by the Drug Plan and Extended Benefits Branch.

SK Residents who received an OAT prescription



*Decrease noted primarily with methadone treatment.

Data covers the period from April 1 to March 31 of each year.

Put into Practice: Case Discussion

Patient age: 35-40 years

Urine drug screen (April 30, before buprenorphine/naloxone (Bup/Nx) induction):

Methadone

Ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine (EDDP) (metabolite of methadone)

Fluorofentanyl

Etizolam

Benzoylecgonine (metabolite of cocaine)

Date	Prescriber	Drug	Dose	Quantity	Day Supply	Pharmacy
April 30	A	Methadone	30mg	3 doses	3	A
April 30	A	Bup/Nx	2mg	4 tabs	5	A
May 3	A	Methadone	40mg	3 doses	3	A
May 5	A	Bup/Nx	8mg	9 tabs	6	A
May 6	A	Methadone	50mg	3 doses	3	A
May 11	A	Methadone	40mg	4 doses	4	A
May 11	A	Bup/Nx	8mg	21 tabs	7	A
May 15	A	Methadone	30mg	3 doses	3	A
May 18	A	Methadone	20mg	3 doses	3	A
May 18	A	Bup/Nx	8mg	21 tabs	7	A
May 21	A	Methadone	10mg	3 doses	3	A
May 27	A	Sublocade	300mg	1 dose	26	B
May 27	A	Methadone	30mg	7 doses	7	A
June 28	A	Sublocade	300mg	1 dose	26	B
July 2	B	Methadone	30mg	7 doses	7	C
August 4	A	Sublocade	300mg	1 dose	26	B

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Conventional initiation of buprenorphine/naloxone (Bup/Nx) requires a period of opioid abstinence to avoid precipitating withdrawal. Microdosing allows transition from a full μ-opioid agonist (e.g. methadone, fentanyl) to a partial μ-opioid agonist (e.g. buprenorphine). Many microdosing protocols exist, including one in the Opioid Agonist Therapy Standards and Guidelines.

For a patient prescribed methadone 30mg daily, the following microdosing protocol could be used:

Day	Bup Dosing	Methadone Dosing
1	0.5mg SL OD	30mg OD
2	0.5mg SL BID	30mg OD
3	1mg SL BID	30mg OD
4	2mg SL BID	30mg OD
5	4mg SL BID	30mg OD
6	8mg SL OD	30mg OD
7	8mg SL in AM and 4mg SL in PM	30mg OD
8	12mg SL OD	STOP METHADONE

Once stabilized on 8-24mg of transmucosal buprenorphine for a minimum of 7 days, patients may be transitioned to Sublocade® (abdominal subcutaneous buprenorphine monthly injection), per the product monograph.

In the above case, methadone (provided by Pharmacy A) was continued invertedly with Sublocade® (provided by Pharmacy B) because the methadone prescription was not cancelled and the concurrent dosing was missed by the pharmacies. The methadone prescribing was maintained while in hospital and on hospital discharge by a Hospital-Based Temporary prescriber.

Tips to avoid the above situation:

- Cancel any outstanding prescriptions (especially if the patient is using different pharmacies).
- Provide clear education to the patient about the treatment plan, especially when introducing a newer, unfamiliar medication like Sublocade®.
- Check PIP prior to prescribing any medication (see POLICY: Prescribing: Access to the Pharmaceutical Information Program (PIP) or electronic Health Record (eHR) Viewer).
- Share lessons learned with colleagues and other health care providers (especially those also involved in the patient's care).

Reference:

Terasaki D., et al. Transitioning Hospitalized Patients with Opioid Use Disorder from Methadone to Buprenorphine without a Period of Opioid Abstinence Using a Microdosing Protocol. Pharmacotherapy 2019;39(1): 1023-9.

Concerned about Prescription Drug Misuse and/or Trafficking?

Call the Prescription Review Program to report misuse of prescription drugs in your community at

1-800-667-1668

and/OR call your local Law Enforcement.

**The Prescription Review Program will accept anonymous calls if there is a reason the caller does not want to be identified.*