unScripted
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IN THIS ISSUE

PRESCRIPTION REVIEW PROGRAM
education | collaboration

OATP Opioid Agonist Therapy Program

prp@cps.sk.ca
oatp@cps.sk.ca

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

cps.sk.ca

Travelling with Medications/Medical Supplies

When travel is within Canada, patients can obtain medications from pharmacies at their local destination if the prescription meets the provincial written requirements of the pharmacy's location.

For travel outside of Canada, patients should check with the embassy to ensure the medication is permitted and any additional requirements (e.g. physician's note) are taken care of.

Before authorizing a large quantity of medications, providers may choose to request confirmation of travel (e.g. trip itinerary). Additional points to discuss with the patient might include plans for/reminders about safe storage; an unexpected, delayed stay; what to do in case of stolen/lost medication; temperature sensitive medications; potential medication interactions (e.g. alcohol); etc. For opioid prescriptions, providers may also consider prescribing Take-Home Naloxone with training.

Did You Know?

- Narcotics are not allowed to be mailed to the USA.
- When visiting the USA, travelers may bring 90 days' worth of medication but only 30 days' worth of narcotics.
- The Netherlands require Schengen certification for travel with medications falling under the Opium Act (e.g. opioids, benzodiazepines, stimulants).
- Medications containing stimulants are prohibited in Japan and travelers risk arrest and imprisonment if in possession (even with a prescription!).
- Large quantities of any medication will be scrutinized in Russia. Travelers must have a physician's note translated to Russian confirming the need for medication, including over-the-counter medication.

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Tips for Travelling with Medications and Medication Supplies:

- Pack medication in a carry-on baggage in the original, labelled containers; the limit of carry-on bags does not apply to medical supplies/equipment.
- Do not combine medication in a single vial.
- Carry a copy of the original prescription and ensure generic and trade names are included, along with the phone numbers of the prescriber and dispensing pharmacy.
- Check with the embassy/consulate website well in advance and just before departure to confirm medication/medical supplies are permitted.
- A travel supply may not be covered by drug insurance plans.

Thank you to 4th year pharmacy student, Marina, for assisting with the gathering of information for this article.

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Government of Canada: Travelling with medication. Retrieved from https://travel.gc.ca/travelling/health-safety/medication

Pharmacy Association of Saskatchewan: Tips for travelling with medications. Retrieved from https://www.skpharmacists.ca/site/patients/tips/travel

U.S. Customs and Border Protection: Traveling or temporarily in the United States and need a prescription medicine sent to me. Retrieved from https://help.cbp.gov/s/article/Article-777?language=en_US

Associated Kyoto Program: Bringing Medications into Japan. Retrieved from https://www.associatedkyotoprogram.org/bringing-medications-japan/#:~:text=As%20mentioned%20above%2C%20all%20medications,you%20risk%20arrest%20and%20imprisonment.

Government of the Netherlands: Can I take my medication abroad? Retrieved from https://www.government.nl/topics/medicines/question-and-answer/can-i-take-my-medication-abroad

Government of Canada: Russia Travel Advice. Retrieved from https://travel.gc.ca/destinations/russia

Words of Wisdom from an Experienced OAT Provider

Summarized, with permission

My greatest fear when I started prescribing Opioid Agonist Therapy (OAT) was in relation to managing the social issues associated with the addiction. I was warned that I needed a social worker and a coordinator to help with all the transitions that would be necessary to manage these patients.

In spite of being refused support workers due to lack of resources, I was not afraid because many of the patients had become part of my family practice. Many were homeless or very transient, moving from location to location. Many ended up in the correctional system.

I have been prescribing OAT for over 15 years across varied settings. The typical 9-5 clinic often does not work for my clients.

Most of our intakes into the correctional system are after 5pm. We receive many clients in the correctional system without any information. It can be a nightmare to track down prescribers and pharmacists, especially over long weekends. Prescribing information on PIP is not often accurate. Many Northern clinics are not easily available, even by phone, on some days.

I currently have about 20 patients on OAT incorporated into my Family Practice. I know them very well as I have delivered their babies and continue to provide family medicine care to them and their families. I will say we have grown together. They can reach me anytime through my clinic's phone system. Many face barriers even with my own staff, but they know how to reach me.

Addiction care should be incorporated into family practice. It would go a long way if all family physicians in Saskatchewan took on patients and were each supported to care for 10-20 patients in their family practice.

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.

To Prescribe or Not to Prescribe Opioids:
Treating Acute and Chronic Pain for Patients Prescribed Opioid Agonist Therapy

- Approximately 20% of Canadians live with chronic pain
- 31-55% of people who use illicit drugs have unmanaged pain

As best practice, non-opioid analgesic options should always be considered before opioid options for all patients. Current guidelines suggest that chronic, high-dosed opioid therapy is rarely indicated as the benefits often do not outweigh the risks.

For patients with opioid use disorder who are experiencing acute or chronic pain, consider consulting the patient's OAT provider prior to prescribing opioids. Sometimes, the buprenorphine or methadone can be adjusted, negating the need for additional opioids. If additional opioids are required, avoid the patient's previously reported opioid of choice and ensure prescribing boundaries are in place:

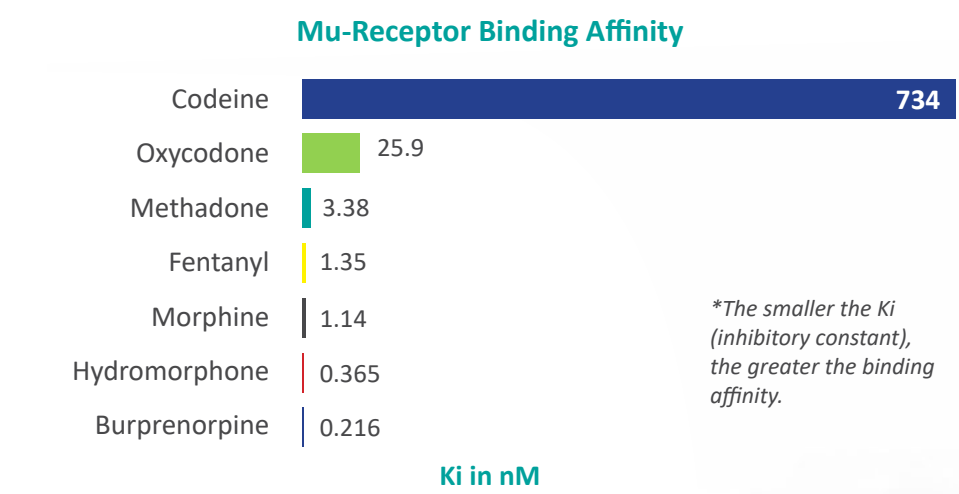
- Develop a clear plan, including a taper/discontinuation strategy;
- Ensure the patient has reasonable expectations (pain will not be a 0/10);
- Patients need to engage with a multi-dimensional approach to manage pain;
- Prescribe the opioid in small amounts (e.g. daily).

Know the Pharmacology Before You Prescribe – It Can Be Complex!

Buprenorphine has a high affinity for the mu-opioid receptor and patients require an opioid selection and dose to out-compete mu-opioid receptors for opioid effect. Buprenorphine can reduce the effects of pure opioid agonists via competition/antagonism at the opioid receptor sites. Combining full agonists (e.g. hydromorphone) can result in adverse effects (e.g. overdose) and relapse without appropriate precautions.

Prescribing chronic opioids with buprenorphine/naloxone

Food for thought… If a patient taking ramipril for hypertension continued to have high blood pressure, would you prescribe perindopril chronically with ramipril?



Thank you to Dr. Larissa Kiesman for allowing adaptation of her presentation, ECHO: Treating Chronic Pain in Patients with SUD/OUD (Series 4, Session 5, Dec. 8, 2021).

References:

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Centre for Addiction and Mental Health (2021). Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. Retrieved from https://www.camh.ca/-/media/files/professionals/canadian-opioid-use-disorder-guideline2021-pdf.pdf

Southwick, F. Buprenorphine in Partially Agonizing Detail. Retrieved from www.careinnovations.org/wp-content/uploads/Frances-Southwick_Improving-Prescribing-of-Medications-for-OUD.pdf

Lexicomp interactions: buprenorphine and hydromorphone

FREE!

FREE ACCREDITED EDUCATION EVENT

The **Canadian Society of Addiction Medicine** and the **College of Physicians and Surgeons of Saskatchewan** have partnered to offer a FREE educational event for Saskatchewan physicians

Physicians are encouraged to attend!
*This event is being offered free to physicians thanks to a generous sponsorship from the CPSS.

Recognizing and Responding to Intimate Partner Violence in Clinical Encounters

Wednesday, November 2, 2022 - 5:30 p.m. to 8:30 p.m.
Delta Bessborough Hotel - Saskatoon, Saskatchewan

CLICK HERE FOR MORE DETAILS
FREE FOOD! MAINPRO+ ACCREDITED!

TO REGISTER: Email prp@cps.sk.ca and ask to be registered for the VEGA session.
Advance registration is required (Max 40 participants). A waiting list will be started once session capacity has been reached.

Drug Spotlight: ZOPICLONE

Zopiclone is indicated for insomnia and has a similar pharmacological profile to benzodiazepines. It is intended for short-term use (≤4 to 8 weeks) in conjunction with non-pharmacological therapies.

Patients should be instructed to wait at least 12 hours after dosing (even in the absence of drowsiness) before driving or engaging in activities requiring alertness. **Zopiclone should be taken as a single ingestion and not re-administered during the same night.**

Monitoring of zopiclone began in 2020; although daily doses of 7.5mg should not be exceeded, a dose of more than 90mg has been prescribed and dispensed in Saskatchewan.

Since zopiclone functions like a benzodiazepine, expert opinion is to treat withdrawal similar to benzodiazepine withdrawal.

Is eszopiclone monitored by the PRP?

Yes - eszopiclone is a stereoisomer of zopiclone and the PRP monitors the Panel of Monitored Drugs in bylaw 18.1 **and** associated salts and/or enantiomers.

References:

Product monograph: Imovane®. Sanofi-aventis Canada Inc. Revised Sep 27, 2018. Retrieved from https://pdf.hres.ca/dpd_pm/00047597.PDF

Product monograph: Teva-zopiclone. Teva Canada Limited. Revised Feb 3, 2021. Retrieved from https://pdf.hres.ca/dpd_pm/00057605.PDF

Metaphi Listserv: Zopiclone Addiction (Mar 29, 2022).

Pinto LR Jr, Bittencourt LR, Treptow EC, et al. Eszopiclone versus zopiclone in the treatment of insomnia. Clinics (Sao Paulo), 71(1):5-9 (2016). doi: 10.6061/clinics/2016(01)02. PMID: 26872077; PMCID: PMC4732384.

Words Matter

Words can impact whether people will seek help and stigmatizing language around substance use disorders is particularly intractable.

The use of stigmatizing language in medical records can transmit bias and affect the quality of care that patients subsequently receive. Bias can influence successive provider attitudes and decision-making.

Self-stigma can deter recovery so setting a good example is important for patients.

Instead of....	Try...
Addict Drug abuser	Individual with substance use disorder
Clean	In recovery
Relapse	Recurrence/set back/return to use
Dirty drug test	Positive drug screen/testing positive for substances
Clean drug test	Negative drug screen/testing negative for substances
Substitution/ replacement therapy	Medication assisted recovery
Stayed clean	Maintained recovery

Want to learn more? CAMH offers a free, self-directed course: Understanding Stigma.

References:

Volkow ND, Gordon JA, Koob, G.F. Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. Neuropsychopharmacol, 46:2230–2232 (2021). https://doi.org/10.1038/s41386-021-01069-4

Park J, Saha S, Chee B, et al. Physician Use of Stigmatizing Language in Patient Medical Records. JAMA Netw Open, 4(7):e2117052 (2021). doi:10.1001/jamanetworkopen.2021.17052

Hammarlund R, Crapanzano KA, Luce L, et al. Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug- and alcohol-use disorders. Subst Abuse Rehabil, 9:115-136 (2018). https://doi.org/10.2147/SAR.S183256

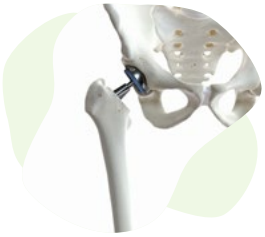
Put into Practice: Case Discussion

Patient age: 60-65 years

A patient stabilized for 1 year on Bup/Nx 16mg daily for the treatment of opioid use disorder is discharged post total hip arthroplasty. While in hospital, the Bup/Nx dose was discontinued two days prior to surgery with the aim of achieving adequate pain management with a full mu-agonist (hydromorphone).

Date of surgery: Jul 8

Date of discharge: Jul 16



Date	Prescriber	Drug	Tablet Strength	Quantity of Tabs	Day Supply Dispensed
Jul 2	A	Bup/Nx	8mg	14	7
Jul 9	A	Bup/Nx	8mg	14	7
Jul 16	Surgeon	Hydromorphone	2mg	42	7
Jul 23	Surgeon	Hydromorphone	2mg	42	7
Jul 30	A	Bup/Nx	8mg	14	7
	Surgeon	Hydromorphone	2mg	42	7
Aug 6	A	Bup/Nx	8mg	42	7
	Surgeon	Hydromorphone	2mg	42	7
Aug 13	A	Bup/Nx	8mg	14	7
	B	Hydromorphone	2mg	21	7
Aug 16	B	Hydromorphone	2mg	21	4
Aug 20	A	Bup/Nx	8mg	14	7
	B	Hydromorphone	2mg	42	7
Aug 27	A	Bup/Nx	8mg	14	7
	B	Hydromorph Contin	3mg	14	7
	B	Hydromorphone	2mg	21	7
Sep 3	A	Bup/Nx	8mg	14	7
	B	Hydromorph Contin	3mg	14	7
	B	Hydromorphone	2mg	21	7

How many issues can you find with the above case?

1. Preoperative Planning

- Buprenorphine should almost always be continued at the preoperative dose (prevents disruption of the regimen, averts potential exacerbation of the underlying disorder(s)/stress-triggered relapse, and the need for buprenorphine re-initiation).

2. Postoperative Pain: Buprenorphine and Opioids (in hospital)

- After analgesic adjuncts have been initiated (e.g. NSAIDs, acetaminophen, gabapentin/pregabalin, ketamine, dexmedetomidine, lidocaine), consider initiating a full mu-agonist (e.g. fentanyl, hydromorphone, morphine) – full mu-agonist dose escalation may be required due to the high receptor affinity of buprenorphine.
  - Take extra care when re-introducing full agonists that may have previously been the patient's drug of choice.
- If inadequate analgesia persists, consider a buprenorphine dose reduction (in consultation with an OAT provider).
- If buprenorphine is reduced in the context of a full mu-agonist, additional monitoring is required.

3. Discharge Planning

- It is almost always appropriate to discharge the patient on some dose of buprenorphine (hospital-based temporary prescribers are permitted to prescribe OAT for a max duration of 72 hours after discharge and must inform the community-based prescriber to avoid double dosing).
- **Discharging on a full mu-agonist alone risks exacerbating underlying opioid use disorder.**
- Cautious prescribing boundaries are required for any discharge with a full mu-agonist (e.g. small quantities dispensed; expected duration clearly communicated; appropriate monitoring and follow-up).

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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.*

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- **Full opioid agonists should not be continued chronically with buprenorphine without consultation with the patient's OAT provider.**
- Ensuring access to a Take-Home Naloxone kit is a risk mitigation strategy.

4. Outpatient Provider Involvement

- The patient's OAT provider should be engaged throughout to assist with managing expectations and facilitating treatment retention (including appropriate OAT maintenance dosing).

5. Community Pharmacy Involvement

- Informing the patient's community pharmacy of hospital admission prevents double dosing and inadvertent access to controlled medications.
- Clearly communicating the discharge medication plan to avoid unintended medication continuation/dosing.

References:

Goel A, Azargive S, Weissman JS, Shanthanna H, et al. Perioperative Pain and Addiction Interdisciplinary Network (PAIN) clinical practice advisory for perioperative management of buprenorphine: results of a modified Delphi process. Br J Anaesth, 123(2):e333-e342 (2019). doi: 10.1016/j.bja.2019.03.044.

Ward EN, Quaye AN, Wilens TE. Opioid Use Disorders: Perioperative Management of a Special Population. Anesth Analg, 127(2): 539-547 (2018). doi: 10.1213/ANE.0000000000003477. PMID: 29847389; PMCID: PMC6523021.

Champagne K, Date P, Forero, JP, et al. Patients on Buprenorphine Formulations Undergoing Surgery. Curr Pain Headache Rep, 26, 459–468 (2022). https://doi.org/10.1007/s11916-022-01046-6

Clarke HA, Manoo V, Pearsall EA, et al. Consensus Statement for the Prescription of Pain Medication at Discharge after Elective Adult Surgery. Can J Pain, 4(1):67-85 (2020). doi:10.1080/24740527.2020.1724775

Discontinuation of Ritalin® Products (IR and SR)

The manufacturing of Ritalin® SR and Sandoz-methylphenidate SR tablets has been discontinued. Apo-methylphenidate SR continues to be available.

Psychostimulants are high-risk medications for misuse and are monitored by the Prescription Review Program. Since longer acting stimulants have a lower misuse potential than shorter acting formulations, maintenance of sustained release formulations (vs a switch to immediate release) is safer for patients and communities. Short acting formulations are easily injected due to their pharmacokinetic profile and ease of crushability.

While there may be differences in bioavailability between brand and generic products, it is uncommon for the differences to be clinically significant. It is rare for a patient to be allergic or intolerant to a specific inactive ingredient.

If patients are concerned about switching to a generic formulation or note clinical destabilization associated with a switch from brand to generic, consider the following steps:

1. Educate the patient that the brand and generic are the same medication (although the medication may appear different in terms of size, shape, etc.).
2. Confirm how the patient is taking the medication.
3. Consider other factors that might contribute to clinical changes (e.g. fragility, weight change, renal fluctuation).
4. Rule out potential interactions (e.g. disease/food/drug).
5. Be aware that requests for particular brands may be a sign of aberrant behaviour and may warrant further discussion/treatment modifications to reduce harm(s) – don't forget to assess social circumstances which might need to be addressed to mitigate diversion.

If tolerance continues to be a concern with generic formulations, a switch to a first-line psychostimulant (e.g. Concerta®, Biphentin®, Foquest®) may be considered. Working with the patient's community pharmacy can be helpful to navigate drug coverage and potential drug shortages (current intermittent shortages of some strengths of Biphentin® and Foquest®).

References:

Drug Shortages and Discontinuations. Saskatoon: medSask; 2022. https://medsask.usask.ca/professional-practice/drug-shortages.php

CADDRA Guide to ADHD Pharmacological Treatments in Canada. Toronto: CADDRA; 2020. https://www.caddra.ca/wp-content/uploads/Final-Laminate-Card-2019_9-1.pdf

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