College of Pharmacists of Manitoba

From the Script to the Medical Examiner: Resources for Pharmacist Intervention

October 10, 2019
Presenter Disclosure

Jill Hardy
Deputy Registrar, College of Pharmacists of Manitoba

No conflicts of interest to declare
Learning Objectives

- Discuss the benefits of the Office of the Chief Medical Examiner (OCME) and its impact on health care practices in Manitoba
- Illustrate the importance of CPhM involvement with the OCME and reflect on the impact of information gathered
- Assess the influence of the Medical Examiner (ME) learnings on policies and regulations thus far
- Analyze a case study and apply learnings to daily practice
- Identify and examine the several resources available for best practices
Part 1

CPhM and the Adult Inquest Review Committee (AIRC)
What is the OCME and the AIRC?

• Office of the Chief Medical Examiner (OCME)
  • The Chief Medical Examiner has the responsibility for the investigation of all unexpected and violent deaths occurring in the Province.

• The OCME has three review committees, meeting monthly:
  • The Children’s Inquest Review Committee (CIRC)
  • The Adult Inquest Review Committee (AIRC)
  • The Geriatric Inquest Review Committee (GIRC)
Deaths that Require an Inquiry

- Accident
  - During or 10 days after an invasive procedure or under anesthesia
- Contagious disease
  - Within 24 hrs after seeking admission to a hospital
- Suddenly or unexpectedly
- Homicide or suicide
  - During, following, or relating to pregnancy
- Poisoning
  - Contracting a disease or condition, injury, or exposure to toxic substance at work place
- Child
  - While in the custody of a peace officer or due to use of force
  - While being imprisoned or detained in a correctional facility, jail or a penitentiary
  - While being a resident at a facility under the MHA or a development centre under the VPLMDA
Benefits of an Audit Committee

- Systemic Collection of Data
- Identify trends
- Interprofessional and multidisciplinary involvement leading to collaboration and information
- Recommendations that lead to changes in practice and policy making
- Ensure individuals receive the care they are entitled to
- No death is “swept under the rug”
The Importance of CPhM Involvement

CPhM’s Mission Statement:

“To protect the health and well-being of the public by ensuring and promoting safe, patient-centred, and progressive pharmacy practice in collaboration with other health-care providers”
CPhM Review of OCME Deaths

Joint Review at Monthly ME Meeting

Letters Requiring a Response

Satisfactory Response

Unsatisfactory Response

FYI Letters
CPhM Review of OCME Deaths
Joint Review at Monthly Meetings

• Collaborative reviews: CPSM Medical Consultant & CPhM staff pharmacist

• All deaths involving prescription medications undergo detailed review:
  • Deceased patient’s DPIN history
  • Toxicology report
  • Autopsy report
  • Photographs of prescription bottles (if available)
CPhM Review of OCME Deaths
Letters Requiring a Response to CPhM

Pharmacy managers asked to respond with the following:

1) Overview of the care provided to the patient
2) Copies of Rxs, including any notes and pharmacist interventions
3) Operational changes and policies instituted to prevent similar situations in the future
4) Additional education undertaken by pharmacy staff
5) Documentation of recommendations/collaboration with prescriber(s)
Part 2

Trends and Numbers
Trends and Areas of Concern Seen from ME Files

- Polypharmacy
- High dose opioids/benzos
- Combo opioids + benzos
- Double doctoring
- No controlled dispensing
- Consistent early fills
- Inappropriate pharmacist Rx’ing
- Evidence of diversion

Trends from the AIRC
Opioid Related Deaths Across Canada

Figure 1. Number and rate of apparent opioid-related deaths by province or territory in 2018.

In 2018, the number of total apparent opioid-related deaths in Canada was 4,588.

The death rate in Canada was 12.3 per 100,000 population for the selected year.
Opioid Related Deaths Across Canada

Figure 1. Number and rate of accidental (unintentional) apparent opioid-related deaths by province or territory in 2018.

In 2018, the number of accidental apparent opioid-related deaths in Canada was 4,303.

The death rate in Canada was 11.6 per 100,000 population for the selected year.
ISMP Infographic on Navigating Opioids for Chronic Pain

- Divides the risk into 4 categories:
  - 0 – 50 MED
  - 50 – 100 MED
  - 100 – 200 MED
  - >200 MED

*MED = Morphine Equivalents per Day

ISMP Infographic on Navigating Opioids for Chronic Pain

As the number of morphine milligram equivalents per day (MME/D) increases, the harms associated with opioid therapy also increase.

<table>
<thead>
<tr>
<th>Drug</th>
<th>MME/D</th>
<th>Dose</th>
<th>MME/D</th>
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<tr>
<td>Codeine Cont1</td>
<td>100mg</td>
<td>30 MME</td>
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<td>Tylenol #3</td>
<td>8 tabs/day</td>
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<td>MS Cont1</td>
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<td>80 MME</td>
<td>100 MME</td>
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Is high dose prescribing saving or sinking you?

There is no safe dose of opioids. Harms and complications can happen at any dose, but are less likely at lower MMEs/D.

There is up to a 5x increase in overdose risk in this range as compared to lower doses. The CDC recommends that prescribing above 90 MME/D be avoided.

ISMP Infographic on Navigating Opioids for Chronic Pain

There is up to a 9x increase in overdose risk in this range as compared to lower doses. Overdoses that happen at doses greater than 100 MME/D are more likely to be fatal.

People on higher doses tend to have higher rates of complications like sleep apnea, generalized pain, addiction, low testosterone levels and disability from work. Most chronic pain can be managed well below 200 MME/D.

Responsibilities of a Pharmacist

Pharmaceutical Regulations

**M3P dispensing requirements**

78(1) A drug listed in the M3P schedule must not be dispensed unless

(a) a prescription that complies with section 77 is dated by the authorized practitioner within three days before the day it is presented at the pharmacy for filling;

(b) the member doing the final check has taken reasonable steps to ensure patient safety under section 83; and

(c) the prescription and patient information is entered in DPIN, subject to a patient’s direction under subsection (3).

 Ensuring patient safety

83 Subject to any practice directions, a member must review each prescription and the patient’s record and take appropriate action if necessary with respect to

(a) appropriateness of drug therapy;

(b) drug interactions;

(c) allergies, adverse drug reactions and intolerances;

(d) therapeutic duplication;

(e) correct dosage, route, frequency and duration of administration and dosage form;

(f) contraindicated drugs;

(g) any other error in the prescription or potential drug therapy problem not mentioned in clauses (a) to (f);

(h) a drug prescribed by a practitioner outside his or her authorized scope of practice; or

(i) a drug that has not been prescribed consistent with standards of care and patient safety.
Responsibilities of a Pharmacist
Ensuring Patient Safety Practice Direction

2.4 The appropriate action to a drug related problem may include one or more of the following, conducted in collaboration with the patient, and the prescriber, where appropriate:

2.4.1 gathering additional information from the patient, the patient’s health record, the patient’s designate or another health care professional;
2.4.2 implementing a plan to monitor the drug related problem and to follow up when required;
2.4.3 assessing the patient’s understanding and willingness of involvement in the plan and its outcomes;
2.4.4 reducing the drug related problem by adapting a prescription as described under the Regulations to The Pharmaceutical Act, Section 68(3);
2.4.5 accessing available lab values or ordering specific laboratory tests in consultation with the prescriber;
2.4.6 advising the patient, and the prescriber, where appropriate, about the drug related problem and discuss an alternative action, where appropriate;
2.4.7 entering into a patient-care relationship with another health care professional to manage the patient’s drug therapy;
2.4.8 refusing to dispense or sell the drug or product to the patient; or
2.4.9 reporting an adverse reaction to the Canadian Adverse Drug Reaction Monitoring Program.

2.5 Documentation
If the licensed pharmacist has determined that an actual or potential drug related problem exists, the appropriate action(s) taken should be documented in the patient’s health record.
Responsibilities of a Pharmacist

Patient Counselling Practice Direction

Required elements of the dialogue when a drug is dispensed or sold to a patient for the first time

2.12 The dialogue under 2.2.1 and 2.2.2 must:

2.12.1 confirm the identity of the patient,
2.12.2 identify the name and strength of the drug being dispensed,
2.12.3 identify the purpose of the drug,
2.12.4 provide directions for use of the drug including the frequency, duration and route of therapy,
2.12.5 identify the importance of compliance and the procedure if a dose is missed,
2.12.6 discuss common adverse effects, drug and food interactions and therapeutic contraindications that may be encountered, including their avoidance, and the actions required if they occur,
2.12.7 discuss activities to avoid,
2.12.8 discuss storage requirements,
2.12.9 provide prescription refill information,
2.12.10 provide information regarding how to monitor response to therapy,
2.12.11 provide information regarding expected therapeutic outcomes,
2.12.12 provide information regarding when to seek medical attention, and
2.12.13 provide other information unique to the specific drug or patient.

A licensed pharmacist, an academic registrant, student (while under direct supervision) or an intern must use reasonable means to comply with the provision of the information listed 2.12.1 through 2.12.13 for patients or their representatives who have language or communication difficulties.

2.13 If a drug-therapy problem is identified during the patient counselling, a licensed pharmacist, academic registrant, or intern must take appropriate action to resolve the problem.
Providing Direction: Termination of patient relationship by the licenced pharmacist

2.2 A licenced pharmacist must carefully consider any decision to discontinue care and use reasonable efforts to resolve any issues affecting the relationship with the patient prior to any final decision to terminating the relationship. If a licenced pharmacist is uncertain whether or not it is professionally acceptable to end a pharmacist-patient relationship, they are advised to seek additional professional advice.
Influence of the ME learnings on CPhM Policies and Regulations thus far...

• Exempted Codeine Practice Direction

• Dimenhydrinate/ Diphenhydramine Consultation

• CPhM Quality Assurance Processes
  • Education
  • Informs Standards of Practice, etc.

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Presenter Disclosure

Meret Shaker
Practice Consultant, College of Pharmacists of Manitoba

No conflicts of interest to declare
Part 3
Case Study and Discussion
Case Study: DN

• 52-year-old female found dead in her home on August 21, 2015
• No evidence of foul play or suicide note was at the scene
• Empty bottles of quetiapine
• PMH: depression, alcohol abuse and smoking, regularly used prescribed opiates for arthritis pain, an episode of “substance intoxication” in November 2014, insomnia, and regularly used OTC acetaminophen products.
• Autopsy: cause of death was determined to be probable cardiac arrhythmia, and mixed drug intoxication was a contributing factor
## DPIN History

- **Date of Death:** August 21, 2015

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<tr>
<th>Generic Name</th>
<th>Date Dispensed</th>
<th>Strength</th>
<th>Quantity</th>
<th>Days</th>
<th>Prescriber</th>
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<td>Aug 18, 2015</td>
<td>300/30/15 mg</td>
<td>240</td>
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<td>Dr. Vee</td>
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Toxicology Report: DN

<table>
<thead>
<tr>
<th>Drug</th>
<th>Level (ng/mL)</th>
<th>Therapeutic Range, if applicable (ng/mL)</th>
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<tr>
<td>Amitriptyline</td>
<td>523</td>
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<tr>
<td>Nortriptyline</td>
<td>104*</td>
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<tr>
<td>Total</td>
<td>627*†</td>
<td>75-200</td>
</tr>
<tr>
<td>Codeine (free)</td>
<td>400*</td>
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<tr>
<td>Morphine (free)</td>
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<tr>
<td>Diphenhydramine</td>
<td>1540*</td>
<td>14-112</td>
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<tr>
<td>Quetiapine</td>
<td>2439*</td>
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*Indicates drugs that were above the therapeutic range
† Tricyclic antidepressants undergo post-mortem redistribution and levels may be slightly elevated in the toxicology report
∞ Nortriptyline is an active metabolite of amitriptyline
≈ Diphenhydramine is the primary constituent of dimenhydrinate
Discussion

1) Controlled Dispensing
   • Consistent requests for early refills

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Date Dispensed</th>
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<th>Days</th>
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</thead>
</table>
| Acetaminophen/codeine/caffeine  | Aug 18, 2015
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   | Apr 19, 2015
   | Mar 22, 2015
   | Feb 26, 2015 | 300/30/15 mg | 240       | 30    | Dr. Vee   | XYZ Pharmacy |
2) Diverted medications
   • Quetiapine on scene never prescribed
   • Alerting pharmacies involved

<table>
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<tr>
<th>Generic Name</th>
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3) Stockpiling
   • Amitriptyline discontinued July 11, 2015
   • Date of Death: August 21, 2015

<table>
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<th>Drug</th>
<th>Level (ng/mL)</th>
<th>Therapeutic Range, if applicable (ng/mL)</th>
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<tr>
<td>Amitriptyline</td>
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<td>75-200</td>
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<td>Nortriptyline</td>
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<tr>
<td>Total</td>
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<td>Codeine (free)</td>
<td>400*</td>
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<tr>
<td>Morphine (free)</td>
<td>15</td>
<td>10-80</td>
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<tr>
<td>Diphenhydramine</td>
<td>1540*</td>
<td>14-112</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>2439*</td>
<td>100-1000</td>
</tr>
</tbody>
</table>
Discussion

4) OTC medications
   • Supratherapeutic levels of DPH/DMH
   • Abuse commonly cited in literature

   • Strategies to prevent misuse:
     1. Track and record all purchases
     2. Keep DPH/DMH stock BTC
     3. 10-30 tabs > 100 tabs
     4. If kept OTC, stock only a limited number of packages
     5. Ensure OTC products within the direct line of sight of a pharmacist
     6. Always inquire about OTC drug use

<table>
<thead>
<tr>
<th>Drug</th>
<th>Level (ng/mL)</th>
<th>Therapeutic Range, if applicable (ng/mL)</th>
</tr>
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<tbody>
<tr>
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</tr>
<tr>
<td>Quetiapine</td>
<td>2439*</td>
<td>100-1000</td>
</tr>
</tbody>
</table>
Take Home Message

• Beware of a “typical” combination of drugs
Part 4

Resources for Pharmacist Intervention
Resources for Pharmacist Intervention

1. Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (CNCP)
2. Center for Effective Practice (CEP)
   a) Opioid Management of Chronic Non-Cancer Pain Tool
   b) Opioid Tapering Template
   c) Managing Benzodiazepine Use in Older Adults
3. CDC Guidelines for Prescribing Opioids for Chronic Pain
4. NAPRA Pharmacist’s Virtual Communication Toolkit
5. CPSM Prescribing Opioids Guidelines
#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (CNCP)

- Guidelines
- Opioid Manager
#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Guidelines
  - Recommendation highlights

**Recommendations 6 and 7: For patients with chronic noncancer pain who are beginning long term opioid therapy**

**Strong Recommendation**

Recommendation 6: We recommend restricting the prescribed dose to less 90mg morphine equivalents daily rather than no upper limit or a higher limit on dosing.

Some patients may gain important benefit at a dose of more than 90mg morphine equivalents daily. Referral to a colleague for a second opinion regarding the possibility of increasing the dose to more than 90mg morphine equivalents daily may therefore be warranted in some individuals.

**Weak Recommendation**

Recommendation 7: For patients with chronic noncancer pain who are beginning opioid therapy, we suggest restricting the prescribed dose to less than 50mg morphine equivalents daily.

The weak recommendation to restrict the prescribed dose to less than 50mg morphine equivalents daily acknowledges that there are likely to be some patients who would be ready to accept the increased risks associated with a dose higher than 50mg in order to potentially achieve improved pain control.
#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Guidelines
- Recommendation highlights

**Recommendation 9:** For patients with chronic noncancer pain who are currently using 90mg morphine equivalents of opioids per day or more

*Weak Recommendation*

We suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy.

Some patients are likely to experience significant increase in pain or decrease in function that persists for more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients.

**Recommendation 10:** For patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering

*Strong Recommendation*

We recommend a formal multidisciplinary program.

Recognizing the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration that includes several health professionals whom physicians can access according to their availability (possibilities include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, an addiction specialist, a psychiatrist, and a psychologist).
#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Opioid Manager

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Dosage form</th>
<th>Initial dose</th>
<th>Minimum time interval for pain relief</th>
<th>Suggested dose increase</th>
<th>Maximum dose/day</th>
<th>50 MED</th>
<th>50 MED</th>
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<tr>
<td>Codeine CR</td>
<td>Tab: 5, 100, 200, 400 mg</td>
<td>&gt;50 mg q 8 h</td>
<td>2 days</td>
<td>&gt;50 mg/d</td>
<td>&gt;200 mg q 8 h</td>
<td>334 mg/d</td>
<td>600 mg/d</td>
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<tr>
<td>Codeine IR</td>
<td>Tab: 15, 30, mg</td>
<td>&gt;10 mg q 4 h p.r.</td>
<td>7 days</td>
<td>&gt;15-30 mg/d</td>
<td>&gt;600 mg q 4 h</td>
<td>333 mg/d</td>
<td>600 mg/d</td>
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<tr>
<td>Hydromorphone CR, PR</td>
<td>CR: 3, 5, 10, 15, 20 mg; PR: 10, 20, 30 mg</td>
<td>&gt;3 mg q 12 h; &gt;4 mg q 24 h</td>
<td>Minimum 2 days, recommended 14 days</td>
<td>&gt;3 mg/d</td>
<td>N/A</td>
<td>10 mg/d</td>
<td>18 mg/d</td>
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<tr>
<td>Hydromorphone IR, ER</td>
<td>Tab: 2, 4, 8 mg</td>
<td>&gt;2 mg q 4-6 h p.r.</td>
<td>7 days</td>
<td>&gt;1-2 mg/d</td>
<td>N/A</td>
<td>10 mg/d</td>
<td>18 mg/d</td>
</tr>
<tr>
<td>Morphine ER</td>
<td>Tab: 15, 30, 60, 100, 200 mg</td>
<td>&gt;10 mg q 12 h</td>
<td>5-10 mg/d</td>
<td>&gt;5 mg/d</td>
<td>&gt;90 mg/d</td>
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<td>Oral solution: 1, 2, 5, 10 mg</td>
<td>&gt;5 mg q 4 h, maximum 40 mg/d</td>
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<td>&gt;50 mg/d</td>
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<td>Oxycodeone CR</td>
<td>Tab: 5, 10, 20, 30, 40, 60 mg</td>
<td>&gt;5 mg q 12 h</td>
<td>Minimum 1-2 days</td>
<td>&gt;5-10 mg/d</td>
<td>&gt;80 mg/d</td>
<td>33 mg/d</td>
<td>60 mg/d</td>
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<tr>
<td>Oxycodeone ER</td>
<td>Tab: 5, 10, 20, 30, 60, 80 mg</td>
<td>&gt;10 mg q 12 h</td>
<td>Minimum 2 days, recommended 14 days</td>
<td>&gt;10 mg/d</td>
<td>N/A</td>
<td>&gt;50 mg/d</td>
<td>60 mg/d</td>
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<td>&gt;8 mg/d</td>
<td>N/A</td>
<td>&gt;23 mg/d</td>
<td>60 mg/d</td>
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<td>Tapentadol ER</td>
<td>Tab: 5, 10, 20, 30, 40, 60 mg</td>
<td>&gt;50 mg q 8 h</td>
<td>&gt;5 days</td>
<td>&gt;50 mg/d</td>
<td>&gt;100 mg/d</td>
<td>Not recommended</td>
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<tr>
<td>Tapentadol ER</td>
<td>Tab: 50, 100, 150 mg</td>
<td>&gt;50 mg q 8 h</td>
<td>&gt;5 days</td>
<td>&gt;50 mg/d</td>
<td>&gt;100 mg/d</td>
<td>Not recommended</td>
<td>360 mg/d</td>
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<td>Tramadol CR</td>
<td>Tab: 100 mg, 200 mg</td>
<td>&gt;150 mg q 24 h</td>
<td>7 days</td>
<td>&gt;75-100 mg q 24 h</td>
<td>&gt;400 mg/d</td>
<td>&gt;300 mg/d</td>
<td>&gt;60 mg/d</td>
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<td>Tramadol IR</td>
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<td>&gt;25 mg q 6-8 h</td>
<td>4 days</td>
<td>&gt;25 mg/d</td>
<td>&gt;300 mg/d</td>
<td>&gt;60 mg/d</td>
<td>&gt;40 mg/d</td>
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</tbody>
</table>

http://nationalpaincentre.mcmaster.ca/opioidmanager/
#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

- Opioid Manager

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**Section C: Maintenance & Monitoring**

- This section is intended to support providers with patients continuing opioid therapy.
- Monitor and document a patient’s response to the opioid therapy through regularly scheduled appointments.

**INITIATION, MAINTENANCE & MONITORING**

These are the key elements to document upon initiating a trial of opioid therapy (3–6 month) and on an ongoing basis for monitoring purposes.

See Appendix B - Initiation, Maintenance & Monitoring Chart for a fillable version of this table that can be inserted into the patient medical record.

**Clinical pearls**

- Opioids increase the risk of gastrointestinal adverse events vs. non-opioid therapy alone (64 more events per 1000 patients treated)
- Identify the lowest effective dose for patients continuing opioid therapy

---

http://nationalpaincentre.mcmaster.ca/opioidmanager/
#1: 2017 Canadian Guidelines for Safe and Effective Use of Opioids for CNCP

Patients that would benefit most from THN:
- Receiving >90 MED
- Past, active, or evolving Opioid Use Disorder
- Multiple comorbidities (e.g. lung disease, depression) receiving/using a concurrent BZD or a combination of sedative drugs
- Reduced tolerance (detox, tapering, rotating)

Take-home Naloxone Kit
**Injected Naloxone**

- 

1. **Signs of an Overdose**
   - Soft/no breath or snoring
   - Pinpoint pupils
   - Blue lips, nails, or skin
   - Cold, clammy skin
   - Limp body
   - Doesn't respond to shouting

2. **Call 911**

3. **Give Naloxone**
   - Break drug ampoule
   - Pull into needle very slowly
   - Inject into large muscle
   - If they aren't breathing after 2-3 min, give another dose

4. **Check The Person's Breathing**
   - Breathing
     - Hand supports head
     - Knee stops body from rolling onto stomach
   - Not Breathing
     - Give compressions until help arrives

5. **Stay Calm**
   - Don't put them in a bathtub/shower
   - Don't stand them up
   - Wait for help to arrive

---

**Intranasal Naloxone**

1. **Signs of an Overdose**
   - Soft/no breath or snoring
   - Pinpoint pupils
   - Blue lips, nails, or skin
   - Cold, clammy skin
   - Limp body
   - Doesn't respond to shouting

2. **Call 911**

3. **Give Naloxone**
   - Peel the package open
   - Place your thumb on the plunger
   - Press plunger firmly into nostril
   - If they aren't breathing after 2-3 min, give another dose

4. **Check The Person's Breathing**
   - Breathing
     - Hand supports head
     - Knee stops body from rolling onto stomach
   - Not Breathing
     - Give compressions until help arrives

5. **Stay Calm**
   - Don't put them in a bathtub/shower
   - Don't stand them up
   - Wait for help to arrive

---

For more information, visit [https://uwaterloo.ca/pharmacy/naloxone-and-opioid-crisis-resources](https://uwaterloo.ca/pharmacy/naloxone-and-opioid-crisis-resources)
## Naloxone Injection Training Checklist

**Responding to an Opioid Overdose**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Unresponsive** | - Stimulate with noise (shout, use their name)  
- Touch (sternal rub), remember, tell the person what you are doing before you touch them |
| **Call 911** | - Put the person in the recovery position if you have to leave them alone  
- Give address and if possible send someone to meet paramedics at the door |
| **Clear Airway & Ventilate** | - Clear airway (removing anything from their mouth), tilt head, lift chin  
- Pinch nose and give 2 breaths  
- Continue 1 breath every 5 seconds until the person is breathing again |
| **Give 1st Dose** | - Snap top off ampoule, draw up all of the naloxone  
- Inject into large muscle (thigh, upper arm, or buttck)  
- Inject at 90°, push plunger until you hear a click (needle will retract) |
| **Evaluate & Give 2nd Dose if Needed** | - Continue to give breaths until they respond (the person is breathing again on their own)  
- After 5 minutes, if the person is still unresponsive, give them a 2nd dose of naloxone  
- Continue breaths until the person is breathing on their own, or until paramedics arrive |
| **Aftercare** | - Naloxone wears off in 20-90 minutes  
- The person will not remember overdosing (explain what happened)  
- Monitor the person for at least 2 hours and do NOT allow them to take more opioids (they could overdose again) |
| **Refill** | - Go to your nearest pharmacy to buy more naloxone |
#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool
b) Opioid Tapering Template
c) Managing Benzodiazepine Use in Older Adults
#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain (CNCP) Tool

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf
#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf
#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool

<table>
<thead>
<tr>
<th>YELLOW FLAGS</th>
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</thead>
<tbody>
<tr>
<td><strong>Assess the following to identify patients with CNCP who are at risk for poor outcomes:</strong></td>
</tr>
</tbody>
</table>
| **Biomedical** | • Severe pain or increased disability at presentation  
• Previous significant pain episodes  
• Multi-site pain  
• Non-organic signs  
• Iatrogenic factors |
| **Psychological** | • Belief that pain indicates harm  
• Expectation that passive rather than active treatments are most helpful  
• Fear-avoidance behaviour  
• Catastrophic thinking  
• Poor problem-solving ability  
• Passive coping strategies  
• Atypical health beliefs  
• Psychosomatic perceptions  
• High levels of distress |
| **Social** | • Low expectations of return to work  
• Lack of confidence in performing work activities  
• Heavier workload  
• Low levels of control over rate of workload  
• Poor work relationships  
• Social dysfunction/isolation  
• Medico-legal issues |

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf
#2: Center for Effective Practice (CEP)

a) Management of Chronic Non-Cancer Pain Tool

- Additional red flags:
  - Forged/altered RXs
  - Opioid/Benzodiazepine/sedative RXs from outside the immediate geographic area
  - Cash payments
  - Inconsistent/early refills
  - Multiple prescribers

https://cep.health/media/uploaded/20180628-CNCP-Rev-4.0FINAL.pdf
#2: Center for Effective Practice (CEP)

b) Opioid Tapering Tool

Reasons to consider opioid tapering, reduction or discontinuation:
- Patient requests dosage reduction
- Problematic opioid behaviour (e.g., diversion, altering the route of delivery, accessing opioids from other sources)
- Clear evidence of opioid use disorder (OUD)

Tapering alone is not likely an effective treatment for OUD. It may require further assessment and possible consultation to identify the optimal therapeutic options.

Adverse effects:
- Experiences overdose or early warning signs for overdose risk (e.g., confusion, sedation, slurred speech)
- Medical complications (e.g., sleep apnea, hyperalgesia and withdrawal mediated pain)
- Adverse effects impair functioning below baseline level
- Patient does not tolerate adverse effects

Opioid dosages >90 MED
- Opioid dosages >50 MED without benefit in improving pain and/or function
- Opioid is combined with benzodiazepines
- Other:

Talking Points

- Provide information about why a taper might be needed:
  - "Chronic pain is a complex disease and opioids alone cannot adequately address all of your pain-related needs."
  - "I think it is time to consider the opioid dose you are on and its risk of harm. The risk of overdose and the risk of dying from overdose go up as the dose goes up."
  - "Did you know that most of the evidence showing benefits from opioid use for chronic non-cancer pain supports relatively low doses (less than 100 MED)?"*
  - "In some people, opioids can make their pain worse rather than better. Hyperalgesia resulting from an opioid is when the opioid makes one more sensitive to pain instead of less."

Ensure patients have clear expectations of tapering:
- "Some patients suffering with pain do better if they reduce their use of opioids."
- "Dose reduction or discontinuation of opioids frequently improves function, quality of life and pain control. This may take some time, and your pain may briefly get worse at first."

Address discrepancies between the patient’s goals and their current pain management:
- "I want to make sure your pain management is as safe as possible and I want to get you back to your regular activities."

Adjust to any resistance to opioid reduction by re-framing the conversation:
- "Opioids can have an effect on your central nervous system – they may be causing fatigue or lessening your ability to do daily activities. It is common to see one’s alertness and function level go down when the opioid dose goes up."
- "Sounds like your pain has not improved even with the high dose you have been trying. It may be time to consider a lower dose."

#2: Center for Effective Practice (CEP)
b) Opioid Tapering Tool

**Section B: How to taper, reduce, or discontinue**

For those on a higher dose and/or longer term opioids there is an increased potential for more challenges to tapering, including withdrawal symptoms.

**General approach**

- **Establish the opioid formulation to be used for tapering**
  - Switching from immediate release to controlled release opioids on a fixed dosing schedule may assist some patients in adhering to the withdrawal plan.
- **Establish the dosing interval**
  - Scheduled doses are preferred over PRN doses (to help with better pain control and withdrawal).
  - Keep the dosing interval constant (e.g. bid).
- **Establish the rate of taper based on patient health, preference and other circumstances**
  - Individualize tapering schedule – there is insufficient evidence to recommend for or against specific tapering strategies and schedules.
  - Slow taper should be followed unless otherwise indicated (e.g. patient preference).
  - Rapid taper over 2–3 weeks

**CAUTION:** Reducing the dose immediately or rapidly over a few days/weeks, may result in severe withdrawal symptoms and is best carried out in a medically-supervised withdrawal centre.

**Example of slow taper**

**Current opioid:** Morphine SR 120mg bid

- **Decrease Morphine SR by 15 mg**
  - **Weeks 1 & 2:** Morphine SR 105mg qam and 120mg qhs
  - **Weeks 3 & 4:** Morphine SR 105mg bid
  - **Weeks 5 & 6:** Morphine SR 90mg qam and 105mg qhs
  - **Weeks 7 & 8:** Morphine SR 90mg bid
  - **Weeks 9 & 10:** Morphine SR 75mg qam and 90mg qhs
  - **Weeks 11 & 12:** Morphine SR 75mg bid
  - **Weeks 13 & 14:** Morphine SR 60mg qam and 75mg qhs
  - **Weeks 15 & 16:** Morphine SR 60mg bid
  - **Weeks 17 & 18:** Morphine SR 45mg qam and 60mg qhs
  - **Weeks 19 & 20:** Morphine SR 45mg bid

Continue until the lowest effective dose is found for the patient.

**Example of rapid taper**

**Current opioid:** Morphine SR 120mg bid

- **Decrease Morphine SR 120mg bid to 90mg bid x 3 days, then 60mg bid x 3 days, then 30mg bid x 3 days, then 15mg bid x 3 days, then 15mg qhs x 3 days, then stop**

**Other methods used to reduce dose, taper or discontinue:**

- **Switch current opioid to another opioid and reduce MED by 25% to 50% – see Opioid Manager Appendix C - Switching Opioids**
- **Switch to opioid agonist therapy such as buprenorphine-naloxone or methadone. If unfamiliar with protocol, clinicians should consult with someone knowledgeable with buprenorphine-naloxone use.**

Online courses are available for providers to learn more about buprenorphine-naloxone use.
#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

<table>
<thead>
<tr>
<th>BENZODIAZEPINES AVAILABLE IN ONTARIO</th>
<th>LONG-ACTING</th>
<th>INTERMEDIATE-ACTING</th>
<th>SHORT-ACTING</th>
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</thead>
<tbody>
<tr>
<td>Benzo diazepine</td>
<td>Formulations</td>
<td>Approximate equivalent oral dose (mg)*</td>
<td>Half-life (hours)**</td>
</tr>
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<td>Chlor Diazepoxide</td>
<td>Capsule</td>
<td>5 mg, 10 mg, 25 mg</td>
<td>10</td>
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<tr>
<td>Clorazapate</td>
<td>Capsule</td>
<td>3.75 mg, 7.5 mg, 15 mg</td>
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<td>Diazepam</td>
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<td>Clobazam</td>
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<td>Clonazepam</td>
<td>Tablet</td>
<td>0.25 mg, 0.5 mg, 1 mg, 2 mg</td>
<td>0.25</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Tablet</td>
<td>0.5 mg, 1 mg, 2 mg</td>
<td>1</td>
</tr>
<tr>
<td>Nitraze pam</td>
<td>Tablet</td>
<td>5 mg, 10 mg</td>
<td>5</td>
</tr>
<tr>
<td>Oxaze pam</td>
<td>Tablet</td>
<td>10 mg, 15 mg, 30 mg</td>
<td>15</td>
</tr>
<tr>
<td>Temazepam</td>
<td>Capsule</td>
<td>15 mg, 30 mg</td>
<td>15</td>
</tr>
<tr>
<td>Triazolam</td>
<td>Tablet</td>
<td>0.125 mg, 0.25 mg</td>
<td>0.25</td>
</tr>
</tbody>
</table>

* Scored  * Equivalent to 5 mg diazepam  ** Parent compound and active metabolite  Bolded = covered by the Ontario Drug Benefit

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

DISCUSS WITH A PATIENT THEIR USE OF BENZODIAZEPINES WHEN THE PATIENT:

- Is 65 or over
- Comes in for a preventative health exam
- Comes in for a prescription renewal or refill
- Has had a recent hospitalization
- Is admitted to long-term care
- Has had a recent fall
- Presents with new cognitive concerns or early onset dementia
- Reports driving difficulty or their family, caregivers or friends reports concerns
- Demonstrates rapid escalation of medication use
- Has an active substance use disorder that could trigger inappropriate or problematic use of benzodiazepines
- Has a potential benzodiazepine use disorder

#2: Center for Effective Practice (CEP)

c) Managing Benzodiazepine Use in Older Adults

## SECTION B: Discontinuing benzodiazepines (continued)

### ALTERNATIVE RATES FOR TAPERING

- Taper by 10% every 1-2 weeks until 20% of the original dose is reached, then taper by 5% every 2-4 weeks.\(^\text{16}\)
- For those experiencing severe side effects or severe anxiety, consider a slower taper of 10% every 2 weeks.\(^\text{14}\)
- For those taking a benzodiazepine for panic disorder, taper the weekly dose by a maximum of 10% per week over a period of 2-4 months.
- For those who have been taking a long half-life benzodiazepine for only a short-term (e.g. up to 4 weeks of clorazepate or clonazepam), taper over 1 week.
- Alprazolam
  - For doses <4mg/day, taper by no more than 0.5mg every 3 days or no more than 0.25mg every week.\(^\text{14}\)
  - For doses ≥4mg/day, even slower tapers over 3+ months are required (e.g. 0.5mg every 2-3 weeks, then slow to 0.25mg every 2-3 weeks when at 2mg/day).\(^\text{14}\)

### TAPERING LONG-ACTING BENZODIAZEPINES

- **Switching to long-acting benzodiazepines for a taper:**
  - Switching to long-acting benzodiazepines may be done (e.g. diazepam, clonazepam), but this has not shown to reduce the incidence of withdrawal symptoms or improve cessation rates more than tapering shorter-acting benzodiazepines.\(^\text{7}\)
  - Long-acting benzodiazepines do however offer advantages when tapering, including fewer rebound symptoms, constant drug levels and ease of formulation.\(^\text{14, 15, 16}\)
  - To reduce the severity of withdrawal symptoms, keep a patient on a long-acting benzodiazepine for at least 2 months following a switch (from a short-acting benzodiazepine) and before initiating a taper from the long-acting benzodiazepine.\(^\text{14}\)

- **To taper long-acting benzodiazepines:**\(^\text{21}\)
  - Taper by no more than diazepam 5mg or clonazepam 0.25mg equivalent/week
  - Adjust rate of taper according to patient's symptoms
  - Slow the pace of the taper once the dose is below 20mg of diazepam equivalent (e.g. 1-2 mg/week)
  - Instruct the pharmacist to dispense daily, weekly or every 2 weeks depending on the dose and patient reliability

For additional examples of tapering approaches see [The Ashton Manual].\(^\text{12}\)

#3: CDC Guidelines for Prescribing Opioids for Chronic Pain

Guideline Resources: Clinical Tools

The Guideline for Prescribing Opioids for Chronic Pain is intended to help providers determine when and how to prescribe opioids for chronic pain, and also how to use nonopioid and nonpharmacologic options that are effective with less risk. The clinical tools below have been developed with you, the primary care provider, in mind, to help you carry out the complex task of balancing pain management with the potential risks that prescription opioids pose.

- Quick Reference for Healthcare Providers
- Urine Drug Testing
- Mobile App
- Pharmacists' Brochure
- Pocket Guide: Tapering
- Fact Sheet

Talk with Patients

Talk with patients about their pain management options and risks of opioid treatments using Conversation Starters.
#4: NAPRA Pharmacist’s Virtual Communication Toolkit

https://napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids
#4 : NAPRA Pharmacist Communication Toolkit

**Strategy**

- Use open questions and invitations.
- Reflect back both facts and feelings to ensure the patient feels heard and understood.
- Acknowledging someone’s experience with opioids helps to build rapport and does not mean you support misuse of opioids.
- Explore the human side of pain by asking questions outlined in the “ACT-UP” acronym: Activities, Coping, Thinking, Upset, People.  

**Sample Dialogue**

- Questions: “What are you doing for your pain? Where is the pain?”
- Invitations: “Tell me what you take.” “Explain your pills to me,” or “Describe what you are able to do each day.”
- Feeling: “You are disappointed about missing the reunion.”
- Acknowledging: “You are in pain.” “Many people are afraid reducing opioids will make their pain worse.”
- Activities: “How is your pain affecting your life (i.e., sleep, appetite, physical activities, and relationships)?”
- Coping: “How do you deal/cope with your pain (what makes it better/worse)?”
- Think: “Do you think your pain will ever get better?”
- Upset: “Have you been feeling worried (anxious/depressed (down, blue)’?”
- People: “How do people respond when you have pain?”

**STOP AND LISTEN**

- Connect with your patients in a private area.
- Be curious, actively listen, and acknowledge patients’ experiences with pain or opioids.

**DROP**

- Stimulate and talk about opioids.

**ROLL**

- With resistance.

[Image: https://napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids]
Schedule 1 – Prescribing Opioids

Attached to and forming part of the Standards of Practice of Medicine.

Preamble

This Standard establishes the standard of practice and ethical requirements of all physicians in Manitoba in relation to prescribing opioids. This Standard excludes the treatment of active cancer pain, palliative care, end-of-life care, opioid replacement therapy, and opioid use disorder. The purpose of this Standard is to assist members in prescribing opioids for maximum safety. Knowledge of the risk to benefit ratio of prescribing opioids has altered over time, so prescribing opioids must address pain, function, and the addiction. It recognizes that:

- Every member is professionally responsible for each opioid prescription the member provides to the patient.
- In prescribing opioids, each member provides their clinical judgment, which is to be that of a physician acting reasonably in the circumstances and is documented.

- Patients living with chronic pain can reasonably expect to experience at least a modest improvement in their pain when treated with opioids. Indiscriminate opioid prescribing is associated with significant patient and societal harm. There is no evidence that long-term opioid treatment is indicated or effective for certain medical conditions including chronic headache disorders, fibromyalgia, and axial low back pain.

- There is valuable information available on prescribing opioids and members should educate themselves through available resources. Three valuable resources affirmed by the College as a national consensus, which may change over time as new evidence emerges, are:
  - The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain
  - The Opioid Manger, a tool designed to support healthcare providers in prescribing and managing opioids for patients with chronic non-cancer pain, http://nationalpaincentre.mcmaster.ca/opioidmanager, both published by the National Pain Centre at McMaster University.
  - Guidelines for Prescribing Opioids for Chronic Pain, US Centers for Disease Control and Prevention, 2017,
    https://www.cdc.gov/mmwr/volumes/65/mm6501e1.htm

Effective January 1, 2019

With Revisions up to and including June 21, 2019

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Take Home Messages

1. Engage patients in meaningful conversations
2. Use Resources and Information Available
3. Collaborate with prescriber(s) and voice your concerns
4. Employ Additional Risk Mitigation Strategies
5. Always Monitor and Reassess
6. Document Relevant Interactions

Controlled Dispensing Lockboxes Suggest Alternatives Naloxone

UDS and Opioid Contracts Drug Disposal Controlled Dispensing
We would like to acknowledge the following resources:

- Surveillance of Opioid Misuse and Overdose in Manitoba. Available at: https://www.gov.mb.ca/health/publichealth/surveillance/opioid.html
- Center for Effective Practice, Practice Tools available at: https://cep.health/
- University of Waterloo, Naloxone and Opioid Resources. Available at: https://uwaterloo.ca/pharmacy/naloxone-and-opioid-crisis-resources
- CDC Guidelines for Prescribing Opioids for Chronic Pain, 2016. Available at: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.pdf
- College of Physicians and Surgeons of Manitoba, Schedule L - Prescribing Opioids Standard of Practice. Available at: https://cpsm.mb.ca/cj39alckF30a/wp-content/uploads/Standards%20of%20Practice/Standards%20of%20Practice%20of%20Medicine.pdf#page=88
- NAPRA Pharmacist’s Virtual Communication Toolkit. Available at: https://napra.ca/pharmacists-virtual-communication-toolkit-engaging-effective-conversations-about-opioids
Questions and Answers