Advance Care Pharmacy

URGENT UPDATE – PLEASE READ

OPIOID EPIDEMIC

The opioid crisis in America continues to escalate and physicians are now being held **criminally responsible** for patients who die from overdose. Recently, pharmacists, too, are being held legally liable due to the "**corresponding responsibility**" they have to identify if a prescription for a controlled substance is issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The DEA has also warned pharmacists to address or resolve "**red flags**," such as cash payments for controlled substances or patients who come to a pharmacy for a prescription but who live far away, before dispensing. In the past, pharmacies have been required to perform a controlled substance inventory every two years. This frequency has increased to every three months in order to identify and prevent diversion. Drug diversion is a serious problem and President Trump is even pursuing the death penalty for convicted drug dealers.

In hospice, the use of controlled substances for the treatment of pain and anxiety are commonplace. However, there are certain combinations of medications that, when prescribed together, alert the pharmacy and the regulatory agencies (Board of Pharmacy, DEA). It is now customary, for a pharmacist to check the controlled prescription history of patients prescribed controlled medications, as well as individual prescriber histories, to **identify abuse and misuse**. In fact, all pharmacists are required to enroll in **CURES** (Controlled Substance Utilization Review and Evaluation System) to access this information.

Hospice providers and pharmacists are responsible for identifying suspicious activity regarding controlled medications. Be advised that the following are "**red flags**" involved in abuse and diversion:

1. Patients that ask for **specific narcotics** and try to dictate their treatment with only narcotics.
2. Patients that show **lack of flexibility** and only want a certain regimen.
3. Requests for certain **"cocktails"** which include **Norco 10/325, promethazine with codeine, carisoprodol (Soma), alprazolam (Xanax) 2mg, and oxycodone (15mg and 30mg)**.
4. Patients that ask for **BLUE oxycodone**.
5. Patients that ask for **YELLOW Norco** or **WATSON brand Norco**.
6. Patients that ask for **RED promethazine/codeine**.
7. Requests for **early refills**.
8. Reports of **lost** or **stolen** or medications or that medication was **not delivered**.
9. Claims that the **quantity was short** (wrong quantity sent).
10. Patients that see **private physicians** and **pay cash** for narcotic prescriptions.

CURES reporting is sent to the DEA weekly by every licensed pharmacy. The report is a collection of ALL Schedule II, III, and IV controlled substances that are prescribed and it DOES NOT tag our patients as "hospice". The **DEA is targeting** certain questionable activity, including:

1. Prescriptions for drugs included in the "cocktail".
2. Names of prescribers that write these prescriptions.
3. Quantities that are dispensed with each fill.
4. Pharmacies that dispense large amounts of scheduled drug prescriptions.

Furthermore, the drug wholesaler's reports monitor the quantities of controlled substances ordered by each pharmacy. By law, the wholesaler is required to report suspicious and unusual purchases by any pharmacy to the DEA. Investigations of pharmacies result in subsequent inspections of individual prescribers.

What can hospice and the pharmacy do to **prevent narcotic abuse and diversion**? ACP suggests the following:

1. **Flag patients** on admission and notify the pharmacy of possible/potential abuse and/or diversion so that the drug profile can be closely monitored.
2. ACP will run **CURES reports** to identify patients using other physicians and/or pharmacies. Hospice will be notified of such patients and a plan of action for future dispensing of narcotics will be required.
3. All narcotic dispensing will be reduced to no more than a **14 day supply**.
4. **Avoid all oxycodone** containing products, including OxyContin and Percocet, unless a medical reason necessitates its use. Patients without a morphine allergy should rarely have a need to use oxycodone to treat pain.
5. ACP recommends **avoiding the "cocktail"** and using alternatives, if appropriate. The following are some suggestions:
    - Refrain from using oxycodone. Use **MORPHINE** for pain, if no contraindications exist.
    - Avoid prescribing Norco 10/325, and USE **Norco 5/325** and **7.5/325**, if necessary.
    - Prescribe **LORAZEPAM**, rather than alprazolam.
    - Avoid promethazine/codeine. Alternatively, use **PROMETHAZINE DM**. For severe cough, consider guaifenesin/codeine (Robitussin AC).
    - Instead of carisoprodol (Soma), use **CYCLOBENZAPRINE** (Flexeril) or **BACLOFEN**.
6. Instead of increasing narcotic doses, try **adding non-narcotic drugs** appropriate for pain control. Some options include:
    - Anti-inflammatory drugs (NSAIDS)
    - Gabapentin
    - Lidocaine 4% patch (OTC)
    - Aspercreme/lidocaine topical cream
    - Low dose steroids
    - Duloxetine (Cymbalta)

Be advised that ACP is not instructing prescribers on how to treat their patients. These are merely suggestions to help fight this nation-wide epidemic. Prescribers will recognize what is appropriate for each patient taking into account the diagnosis and medical history. Remember that the greatest potential for abuse and diversion will take place for hospice patients residing at home (and not facilities). **Currently, California law (Health and Safety Code Section 11165.1) requires all California licensed prescribers authorized to prescribe scheduled drugs to register for access to CURES (https://oag.ca.gov/cures).** This valuable resource assists health care providers ensure appropriate prescribing and dispensing of Schedule II, II, and IV controlled substances. Together we can make an impact on this problem and prevent diversion without affecting patient care.