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Safe Prescribing of Drugs with Potential for Misuse/Diversion FAQs

The following attempts to address some of the questions raised by the profession.

Why is the College's professional standard described as legally enforceable?

The newly revised professional standard evolved from a previous version developed in 2012 by the College's Prescription Review Program called *Prescribing Principles*, which, as a "guideline," did not prevent an increasing toll of prescription drug misuse and overdose deaths in this province. Additionally, clinical guidelines developed by the National Opioid Use Guideline Group (NOUGG) in 2010, an initiative sponsored by this and other Canadian medical regulatory authorities, have also apparently not been effective in preventing the increasing reliance of prescribers on long-term opioid treatment for chronic non-cancer pain. The current document comprises 15 standards, which are enforceable under the *Health Professions Act* thereby making them more authoritative, and an additional 11 guidelines, which outline a recommended course of action.

Do physicians have to stop prescribing drugs with potential for misuse/diversion?

No, each of these classes of prescription medication is indicated for some patients. The key message contained in the standard is that physicians should more carefully consider both starting these medications and/or continuing them for long-term use because of the risks involved both for the individual patient and the public at large. That is not to say that no patients should be prescribed these medications. The decision to prescribe however, even when the patients have been "inherited" from another physician or are legacy patients who have been on the medication for many years, should be based on documented and careful patient assessment and treatment rationale. It is unacceptable to refuse to treat patients solely on the basis of their long-term medications or medical diagnosis. The newly revised standard does not support inappropriate withdrawal of long-term prescription medications. It endorses an empathetic discussion of benefits versus harms of long-term prescription medications with patients. Where tapering to a lower dose or to discontinuation is the clinically appropriate course, physicians are advised to taper slowly to minimize physical and psychological withdrawal.

Do all patients need to receive less than 90 mg MEDD?

Standard #5 requires documentation of the rationale for all prescriptions of opioid medication, and avoidance of higher doses unless there is clinical indication for this. Physicians must critically analyze medication regimens for chronic non-cancer pain and other complex patients, and exercise judicious, safe prescribing. Risks associated with concurrent medical conditions (e.g. sleep apnea, chronic lung disease, cognitive impairment, etc.) must be carefully reassessed at intervals. Some physicians may have misinterpreted the document as a standard of dosage alone when it was intended to be a standard of

documentation of thoughtful prescribing. It does not say that a physician must not prescribe >90 MME per day (or MEDD). It states that if prescribing greater than 90 mg MEDD, physicians must carefully document the rationale for their decision, and must frequently reassess the dose.

Why does this standard speak to 90 mg MEDD when the previous NOUGG guidelines referred to 200 mg MEDD as being the "watchful dose"?

The literature review that preceded the 2010 NOUGG guidelines began in 2008. Current medical evidence, as reviewed most recently in the March 2016 US Centers for Disease Control and Prevention's (CDC) *Guidelines for Prescribing Opioids for Chronic Pain* , has identified the lack of evidence for supporting high-dose opioid use in chronic non-cancer pain. The College is aware that the NOUGG guidelines are also currently under review and a new version is expected in 2017. It is expected the new NOUGG guidelines will reference a lower "watchful dose" than it did in 2010.

Does the 90 mg MEDD include methadone?

No. The College recognizes that the morphine equivalent for doses of methadone in patients with chronic non-cancer pain and/or opioid use disorder can be significantly higher than 90 mg MEDD.

What if the patient is on opioids and benzodiazepines? The standards say that benzodiazepines can only be prescribed as a taper.

Benzodiazepines should not be prescribed as an ongoing prescription if the patient is also on long-term opioid treatment (LTOT). This does not refer to patients who intermittently use an opioid medication. There is no clinical data to support this long-term combination, and coroners' data shows it to be unsafe. Physicians should discuss these issues with their patient and suggest a choice for monotherapy. If and when tapering opioids, and more especially benzodiazepines, physicians should do so slowly to minimize withdrawal discomfort and psychological distress. And, they should develop a treatment plan and reasonable timeline for the taper, including the pharmacist when appropriate. Blister packing can be a very useful strategy in this context.

Why did the College include stimulants in a professional standard about opioids?

The professional standard is not intended to address only opioids, or benzodiazepines, or stimulants. The College knows from both clinicians and law enforcement that these three groups of prescription medications are the most widely misused and diverted. Although it has not been possible to avoid reference to patients with chronic non-cancer pain, the standard is not focused on a single group of patients or a single diagnosis.

Standard #14 states that physicians must prescribe "a one-month supply or 250 tablets, whichever is less." Does that mean that patients on a once- or twice-daily medication can only be prescribed dispenses of 30 to 60 tablets?

The College has reviewed this specific statement and recognizes that it may be too restrictive. The standard will be edited to read "a three-month supply or 250 tablets, whichever is less."

Does the standard apply to palliative care patients?

No. As stated in the standard: The College acknowledges the appropriate role of pharmacotherapy in the context of active cancer, palliative, and end-of-life care.

Standard # 4 says not for headache, fibromyalgia or back pain. Why?

To clarify, this refers to LTOT, not intermittent or PRN use of opioids. There is not good medical evidence to support continuous daily opioid treatment of these conditions.

What other resources can physicians offer their patients with chronic pain?

Medication is just one part of the treatment plan for most chronic and nonmalignant pain conditions.

Patients may access:

- chronic pain self-management workshops for patients from Self-Management BC: www.selfmanagementbc.ca
- resources from PainBC: www.painbc.ca

The College encourages physicians not to write off the option of offering physical or exercise therapy to patients who do not have the coverage or personal resources for physiotherapy or rehabilitation programs. Physicians can prescribe simple exercise regimes and monitor functional improvement where other resources are not available. Additionally, patients who do not have access to psychologists may still benefit from advice from their physician about cognitive behavioural therapy.

Patients with acute pain need enough medication to bridge them to community follow-up. What if three to seven days is not enough?

Short-term prescriptions should be enough to get patients with acute pain to their regular prescriber. Large quantities are never advisable. The duplicate prescription can be written for a total quantity, but specify part fills. For example, "*Total quantity 300 tablets. Dispense 100 tablets every two weeks*." Dispensing smaller volumes is one way to foster compliance, prevent diversion and potential overdose, and prevent wastage. Patients should be directed to take unused medication to the pharmacy for safe disposal.

Is it appropriate for patients who have been on long-term opioid therapy for many years to be told by a physician that their prescriptions will be stopped immediately?

The only situation in which this approach might be considered appropriate is if the patient's urine drug testing (with laboratory confirmation of the optimal sample by gas chromatography-mass spectrometry, particularly for semi-synthetic and synthetic opioids) showed no evidence at all of the opioid being prescribed. In all other cases, this approach might be considered clinically inappropriate. The College would encourage any patient or physician aware of such a case to contact the College.