The Opioid Crisis & You
Please logon to www.ascp.com/qa and find the session to ask your questions

Nakia A. Duncan, PharmD, BCGP, BCPS
Assistant Professor - Geriatrics
Texas Tech School of Pharmacy

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#ASCP50

Nakia A. Duncan, PharmD, BCGP, BCPS

• Assistant Professor – Geriatrics, Texas Tech
Disclosure – Nakia A. Duncan, PharmD, BCGP, BCPS

- Dr. Duncan has no actual or potentially relevant financial relationship to disclose and no conflicts of interest in relation to this activity.

Objectives

- Describe the Opioid Crisis.

- Discuss the efforts that have been made to combat the Opioid Crisis.

- Identify the role that pharmacists have in the Opioid Crisis.
Opening Activity: Pick a Card

A B C

Response

A: What is one thing you do if you have opioid addiction?

B: What is one thing you would do to help a dear family member with an opioid addiction?

C: What is one thing you would ask a doctor who prescribed opioid pain medication for you?
“Houston, we have a problem”

Epidemiology: The Numbers

- 66% Drug overdose deaths involving an opioid
- 115 Average # of Americans daily who die from an opioid overdose
- 4x Change in amount of Rx opioids sold between 1999 & 2000
- $78.5 billion Lost productivity & costs to the criminal justice system in 2016

Rise in Opioid Overdose Deaths

We Need Solutions...

More people are dying from prescribed medications than illegal substances.
Health and Human Resource’s Priorities

- Improving access to treatment and recovery services
- Promoting use of overdose-reversing drugs
- Strengthening our understanding of the epidemic through better public health services
- Providing support for cutting-edge research on pain and addiction
- Advancing better practices for pain management
Treatment & Recovery Programs

Relapse

Relapse rates for people treated for substance use disorders are compared with those for people treated for high blood pressure and asthma.
Promoting Overdose-reversing drugs

WARNING
THE FOLLOWING VIDEO CONTAINS GRAPHIC CONTENT THAT MAY BE DISTURBING TO SOME VIEWERS. DISCRETION IS ADVISED.
Signs of Overdose

- **Overdose Stage**
  - Get them up, walk them around, keep them talking
    - Slow, slurred speech
    - Slack muscles, difficulty holding self up
    - Sleepy but still responsive

- **Unresponsive Stage**
  - Immediate response needed
    - Unresponsiveness, even to shouting
    - Unconsciousness
    - Slow, shallow breathing <12/minute
    - Pale, clammy skin, loss of color
    - Blue or gray face, especially around the lips or fingernails
    - Loud, uneven snoring or gurgling noises
    - Not breathing
    - Faint or no pulse


Naloxone (Narcan)

- Naloxone is a pure opioid antagonist that competes and displaces opioids at the MU-opioid receptor sites
- **Indication:** treatment of an opioid emergency (overdose/unresponsiveness)
- **Dose:** 4 mg/0.1 mL
- Administered intravenously, intramuscularly, subcutaneously & intranasally
- **Onset of action:** 3-5 min
- **Duration of Action:** 30-60 min, which requires the need for 2-3 repeated doses if no appropriate response

Naloxone: Training & Dispensing

• Many states require that prior to dispensing, pharmacist must complete 1 hour accredited CE

• At minimum training shall include:
  • When and when not to dispense Naloxone/Narcan
  • How to work with the patient when selecting which opioid antagonist to dispense
  • When to administer Naloxone/Narcan

• Authorized pharmacists that are in active and good standing may dispense an opioid antagonist to a recipient in any of the approved formulations

Naloxone: Training & Dispensing

• Approved formulations:
  • Intramuscular Naloxone aqueous solution multi-dose vial or pre-filled syringe (EXCLUDING auto-injector such as Evzio or equivalent)
  • Intranasal Naloxone
  • Naloxone Nasal Spray

• Pharmacist may also dispense other items necessary for the administration of opioid antagonist
  • Syringes
  • Mucosal atomization devices

• After Naloxone is given
  • May feel withdrawal symptoms
Self-Assessment Question 1

• A friend of yours wants to know when you should actually use Narcan. Which of the following is accurate (select all that apply)?

A. When you find someone sleeping in their car
B. When you find someone using heroin but, talkative
C. When you find someone vomiting outside of the bar
D. When you find someone unresponsive, even to shouting
Strengthening our understanding of the epidemic through better public health services

Role of Community Health Workers (CHWs)

Who are they?
- Front line public health workers
- Hired by health care agencies
- Disease or population-specific focus/training
- Education: ranges from certificate to undergraduate degree
- Have similar backgrounds, cultural beliefs and values

How can they help?
- Establish trust & rapport
- Case finding & referrals
- Patient navigation
- Health education
- Integrated community based approaches
- Social support
Providing Support for Research on Pain and Addiction

Helping to End Addiction Long-Term: NIH HEAL Initiative

- Improvement for Opioid Misuse & Addiction
  - New formulations to improve treatment compliance, prevent relapse and risk of misuse
  - Stronger, longer formulations to counteract opioid overdose

- Enhancing Pain Management
  - New non-addictive pain treatments
  - Identify new targets for pain treatment
NSS-2 Bridge Device

FDA grants marketing authorization of the first device for use in helping to reduce the symptoms of opioid withdrawal

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reSET-O

- The patient begins working and learning with reSET-O, completes lessons, answers quiz questions (fluency training), and reports substance use, cravings, and triggers. reSET-O also notifies patients with reminders to take their buprenorphine (note: this feature is voluntary)

- reSET-O includes a CM system that gives the patient a chance to win rewards for lessons completed and negative drug screens achieved during the 12-week (84-day) therapy period.

Advancing better practices for pain management

CDC 2016 Guidelines* for Opioids in Chronic Pain

1. Opioids are not 1st line therapy
2. Establish Goals for Pain and Function
3. Discuss Risks and Benefits
4. Use Immediate-release opioids when starting
5. Use the lowest effective dose
6. Prescribe short durations for acute pain
7. Evaluate benefits and harms frequently
8. Use strategies to mitigate risk
9. Review PDMP Data
10. Use Urine Drug Testing
11. Avoid Concurrent Opioid and BZD Prescribing
12. Offer treatment for opioid use disorder

* Excludes: active cancer, palliative care, and end-of-life

CDC Guideline for Prescribing Opioids for Chronic Pain http://www.cdc.gov/drugoverdose/prescribing/guideline.html
CDC Guidelines #1

Opioids are not 1st line
Multimodal therapy
Be aware of other non-opioid analgesics/adjuvants
Selection of the correct agent

Adjuvants
- Anticonvulsants
- Antidepressants
- Muscle Relaxers
- Steroids
- Bisphosphonates
- Cannabinoids
- Ketamine
- Lidocaine
- Botox
- CCB/Clonidine
- MISC

CDC Guidelines #2-4

- Establish Goals for Pain & Function
  - Realistic pain goals
  - Balance between function and pain relief

- Discuss risk and benefits
  - Patient specific medication selection
  - Consider Special populations

- Use Immediate Release opioids when starting
  - Healthcare education
  - Understanding of formulations
  - Medication Error
CDC Guidelines #5

- Use the lowest effective dose

- Reassess risk vs benefit when increasing dosage to > 50 Morphine Milligram Equivalents (MME) /day

- Should avoid > 90 MME/day (or carefully justify a decision to titrate dosage > 90 MME/day)

### Equi-analgesic Opioid Dosing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equianalgesic Doses (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenteral</td>
<td>Oral</td>
</tr>
<tr>
<td>Morphine</td>
<td>10</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>0.3</td>
</tr>
<tr>
<td>Codeine</td>
<td>100</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>NA</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
</tr>
<tr>
<td>Meperidine</td>
<td>100</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>10°</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>1°</td>
</tr>
<tr>
<td>Tramadol</td>
<td>100°</td>
</tr>
</tbody>
</table>

*Not available in the US


#CDC Guideline for Prescribing Opioids for Chronic Pain http://www.cdc.gov/drugoverdose/prescribing/guideline.htm

McPherson ML. Demystifying Opioid Calculations. ASHP 2011

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CDC Guidelines #6

- Prescribe the shortest durations for acute pain

- CDC’s recommendation for Acute pain is 3 days or less is often sufficient. More than 7 days is rarely needed.
Self-Assessment 2

- 84 y/o female with a recent hip fracture that has been repaired. She is now transferred to your skilled nursing facility.

- Upon admission she is moaning and crying in pain. She is in great health otherwise with normal renal/liver function. No other opioids or CNS agents are listed on her hospital discharge paperwork.

- The admitting physician wants to start Norco 7.5/325 Q4H PRN but is worried about “opioid regulations” and has a couple questions for you first.

Self-Assessment Question 2

- **Physician Question 1**

  - How many OME would I be prescribing if she takes all doses while awake (Norco 7.5/325 Q4H PRN) assuming she sleeps 8 hours at night?
    - A. 15
    - B. 20
    - C. 25
    - D. 30
Self-Assessment Question 2

**Physician Question 1**
- How many OME would I be prescribing if she takes all doses while awake (Norco 7.5/325 Q4H PRN) assuming she sleeps 8 hours at night?

A. 15  
B. 20  
C. 25  
D. 30

**Explanation:**
- 24 H – 8H (sleeping) 16 H total awake /4 = 4 possible doses  
- 4 * 7.5 = 30  
- Hydrocodone 1:1 morphine

Self-Assessment Question 3

- **Physician Question 2**

- How many days should I prescribe Norco?
  A. 7  
  B. 14  
  C. 30  
  D. 90
Self-Assessment Question 3

Physician Question 2

• How many days should I prescribe Norco (Hydrocodone-Acetaminophen)?

A. 7
B. 14
C. 30
D. 90

• Rational
• Since the patient has an acute pain would prescribe the a short duration of opioids and re-evaluate the need for continued therapy.

CDC Guidelines #7

• Evaluate benefits and harms frequently

• Evaluate benefit/risk within 1-4 weeks of starting opioid

• Continue to evaluate every 3 months

• If benefits do not outweigh risks opioid should be tapered and discontinued.
CDC Guidelines #8 & 9

- Use strategies to mitigate risk
  - Incorporate plans to reduce risk
  - Offer naloxone when factors that increase risk of opioid overdose
- Screening
  - Opioid Risk Tool
  - History of overdose
  - History of substance abuse
- Selection: Abuse-Deterrent Formulations

Opioid Risk Tool (ORT)

- Validated questionnaire
- Predicts which patients will display aberrant drug-related behaviors
- ORT is a 5 item checklist
- Completed by a clinician or patient themselves
Consider Abuse-Deterrent Formulations

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic</th>
<th>Abuse Deterrent Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arymo ER</td>
<td>Morphine</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Embeda ER</td>
<td>Morphine/Naltrexone</td>
<td>Agonist-Antagonist</td>
</tr>
<tr>
<td>Hysingla ER</td>
<td>Hydrocodone</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Morphabond ER</td>
<td>Morphine</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Opana ER</td>
<td>Oxymorphine HCl</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Oxaydo</td>
<td>Oxycodone</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Targiniq ER</td>
<td>Oxycodone/Naloxone</td>
<td>Agonist-Antagonist</td>
</tr>
<tr>
<td>Trasyca ER</td>
<td>Oxycodone/Naltrexone</td>
<td>Agonist-Antagonist</td>
</tr>
<tr>
<td>Vantrela ER</td>
<td>Hydrocodone</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Xtampza ER</td>
<td>Oxydocone</td>
<td>Crush/ extraction resistant</td>
</tr>
<tr>
<td>Zohydro ER</td>
<td>Hydrocodone</td>
<td>Crush/ extraction resistant</td>
</tr>
</tbody>
</table>

CDC Guidelines #9

- **Review PDMP Data:**
  - Collects and monitors prescription data for all schedule II-V controlled substances.
  - Can be accessed by physicians, nurses, pharmacist and their respective delegates.
  - Takes about a minute to run a single PMDP reports and several reports can be run at a time.

- **Monitoring 2016 recommendations:**
  - Review PMP initially and periodically
  - Periodically is not defined
  - In several states this is mandatory prior to prescribing and dispensing
CDC Guidelines #10

- Use Urine Drug Screen Testing
  - Many OTC, RX, and herbals can cause false positives
  - There may also be false negatives
  - Need to consider the assay accuracy, possible contamination, alterations
  - Dangers of UA inappropriate interpretation

CDC Guidelines #11

- Avoid Concurrent Opioid and BZD Prescribing
- AGS Beers List Criteria 2019
  - Concomitant use of 3+ CNS active drugs
  - Recommendation: when using an opioid reduce any other CNS active medication

CDC Guideline for Prescribing Opioids for Chronic Pain http://www.cdc.gov/drugoverdose/prescribing/guideline.html
CDC Guidelines # 12

• Offer treatment for opioid disorder

Methadone (Dolophine®)

Buprenorphine (Butrans®, Buprenex®)

Naltrexone (Revia®, Vivitrol®)

Not an exhaustive list; refer to The American Society of Addiction Medicine Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

Self-Assessment Question 4

• A 68-year-old male is admitted into the hospital after a motor vehicle accident with broken arm, leg and multiple contusions. He is being discharged with home health. He still has moderate pain from this acute injury but is reluctant to use opioids outpatient due to h/o opioid use disorder.

• Which of the following would be the best recommendation?
  A. OxyContin + Narcan
  B. Oxaydo + Narcan
  C. MorphaBond ER + Narcan
  D. Norco + Narcan
Self-Assessment Question 4

- A 68-year-old male is admitted into the hospital after a motor vehicle accident with broken arm, leg and multiple contusions. He is being discharged with home health. He still has moderate pain from this acute injury but is reluctant to use opioids outpatient due to h/o opioid use disorder.
- Which of the following would be the best recommendation?
  A. OxyContin + Narcan
  B. Oxydo + Narcan
  C. MorphaBond ER + Narcan
  D. Norco + Narcan

Have our Efforts Worked?
<table>
<thead>
<tr>
<th>Annual Surveillance Data 2000-2017</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA/ER opioid prescribing rates (per 100 persons)</td>
<td>2.2 - 12.7</td>
<td>1.9 - 11.0</td>
</tr>
<tr>
<td>High-dosage Opioid prescribing rates &gt;90 OME/day</td>
<td>1.7 - 12.0</td>
<td>1.4 - 9.8</td>
</tr>
<tr>
<td>Rates of drug overdose deaths</td>
<td>6.9 - 41.5</td>
<td>6.9 - 52.0</td>
</tr>
</tbody>
</table>
Understand the Challenges in Practice

- Limitations on scripts for acute pain greater than 7 days
- Fill quantity limits on short acting opioids
- Limitations to 50 OME per script
- Difficult to discern acute vs chronic opioid.
- ICD10 Codes needed
  - Cancer pain ICD code is G89.3
  - Chronic pain syndrome is G89.4

Understand the Challenges in Practice

- Restrictions
  - Prior Authorization Required for many new long-acting opioids
  - Stricter criteria for methadone and fentanyl
  - Substitution of abuse deterrent oxycodone ER

- Drug Shortages
  - Reduction in amount of drug being manufactured
What is my Role?

- Be aware of drug shortages
- Perform medication reconciliations
- Become involved with the discharge planning process
- Consider using ePA’s (ex: coverymeds.com)
- Assess and monitor pain
- Use non-opioid options for pain
- Use multimodal therapies for pain
- Calculate and document OME/day for patients
- Develop clinical decision making tools
- Use EMR functionalities
- Be a part of the opioid stewardship committee

What is my Role?

- Provide evaluations for tapering of opioids
- De-prescribe of concomitant CNS agents (if possible)
- Use screening and monitoring tools
- Document mid-refill dose adjustments
- Place orders for naloxone in high risk patients
- Ensure that restrictions to opioids exclude: active cancer, palliative, and end-of-life patients
- Education!
  - Patients & families
  - Healthcare providers
  - Pharmacy Students
Reflective Activity: Remember your Card

A

B

C

Response

A: What is one thing you do if you have opioid addiction?

B: What is one thing you would do to help a dear family member with an opioid addiction?

C: What is one thing you would ask a doctor who prescribed opioid pain medication for you?
Reflection

Conclusions

- Misuse and Abuse of opioids has lead to an epidemic
- The HHS has a 5 tier approach to combat this crisis that includes both reactive and proactive strategies
- The CDC 2016 guidelines provide clinical based practice support for managing pain when using opioids
- Several states require pharmacist to have 1 hour CE on opioid abuse
- All pharmacist regardless of practice site or interest have a role we can play in combating the opioid crisis.
References

- Rudd RA, Aleshire N, Zibbell JE, Gladden RM. Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. MMWR 2016; 64(50); 1378-82.
- McPhearson ML. Demystifying Opioid Calculations. ASHP 2011
- CDC Guideline for Prescribing Opioids for Chronic Pain http://www.cdc.gov/drugoverdose/prescribing/guideline.html

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Social Q&A

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