Opioid Use Disorder (OUD)- Pharmacist's Role

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Learning Objectives

- Understand the different roles of a pharmacist
- Evaluate ways pharmacists can positively impact the treatment of Opioid Use Disorder
- Understand the impact of Clinical Pharmacy Services in patient care

Different Roles of A Pharmacist

- Retail Setting (CVS, Walgreens, Independent Chains, etc.)
- Hospital Setting (Central Distribution, Clinical)
- Outpatient Clinical (CVRR, Psychiatry, Oncology, HIV/ID, etc.)
- Academia
- Research/Industry

Image accessed: https://www.commonwealthfund.org/publications/issue-briefs/2019/mar/pharmacy-benefit-managers-practices-controversies-what-lies-ahead

Pharmacist's Role in OUD

- Collaborate with prescriber
- Assess for misuse potential
- Naloxone access (promote harm reduction)
- Medication counseling
- Avoid stigmatizing language
- Utilize SBIRT- Screening, Brief Intervention, Referral to Treatment
- Clinical pharmacy services

Opioid Use Disorders: Interventions for Community Pharmacists. (2019). Retrieved May 23, 2022, from https://cpnp.org/guideline/opioid

Collaborate with Prescriber

- Perform pill counts
- Review prescription drug monitoring program
- Enforce policy of no early refills
- Hold patient accountable to treatment agreement
- Stay in direct communication
  - Voice Concerns
  - Drug Interactions

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Misuse Potential- Red Flags

- Use of many pharmacies and doctors
- Obtain prescription from provider outside of their scope of practice
- Prescriptions with high dosages/quantities
- Pays in cash/will not use insurance coverage
- Demands certain brands of medication
- Requests early refills frequently
- Fills only controlled substance despite having other prescriptions

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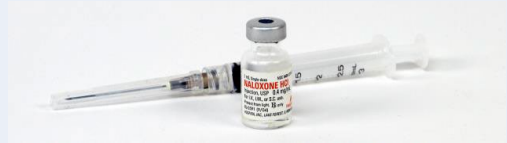
Naloxone Access

- Considered for all patients exposed to opioids
  - Pain, misuse, risk of accidental exposure, family members
- Overdose risk factors:
  - Benzos and alcohol, opioid addiction/SUD, comorbid mental illness, recent incarceration, etc.
- Naloxone for home use can be intramuscular or intranasal

Naloxone Access: A Practical Guideline for Pharmacists. (2019). Retrieved May 23, 2022, from https://cpnp.org/guideline/naloxone

Naloxone Formulations

Type	Contents	Instructions	Image
Intranasal	2 mg/0.1 mL 4mg/0.1 mL 8mg/0.1 mL	One spray into nostril upon signs of opioid overdose. Call 911. May repeat x 1.	 
Intramuscular	0.4 mg/mL vial 1 mg/mL vial 5mg/0.5 mL vial	Inject IM upon signs of opioid overdose. Call 911. May repeat x 1.	

Naloxone Access: A Practical Guideline for Pharmacists. (2019). Retrieved May 23, 2022, from https://cpnp.org/guideline/naloxone

Naloxone Storage

- Store in an easily accessible place in the original package at room temperature
- Avoid light exposure
- The shelf life is typically 12 to 18 months
  - If stored correctly naloxone should be effective up until BUD date on packaging
- Do not insert naloxone into prefilled syringe until ready to use
  - Once inserted it expires within 2 weeks
- Monitor expiration and replace when expired
  - If no other alternatives exist at the time, administer expired naloxone

Naloxone Access: A Practical Guideline for Pharmacists. (2019). May 23, 2022, from https://cpnp.org/guideline/naloxone

Supporting Laws and Regulations

Law/Regulation	Explanation
Good Samaritan	Protects individuals who call for help at the scene of an overdose from being arrested for drug possession
Liability protection/third party administration	Protects the prescriber, pharmacist, and the bystander who may be administering naloxone. It also allows bystander to be prescribed naloxone for use on opioid overdose victims.
Collaborative Practice Agreement/Standing Order	Allows pharmacists to dispense naloxone to at-risk individuals without a traditional prescription. Recent study found that states with this law saw significant decrease in opioid related mortality.

Naloxone Access: A Practical Guideline for Pharmacists. (2019). Retrieved May 23, 2022, from https://cpnp.org/guideline/naloxone

Buprenorphine Considerations

- Ensure appropriate quantity available
- Assist with issues that could delay dispensing
  - Conversions, dosage formulations, manufacturer coupons, vouchers, and savings program
- Induction process requires frequent refills
  - Adherence checks
  - Wellness checks
  - Supervised dosing

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Counseling Points for Buprenorphine

- Sublingual tablet should be kept under tongue until completely dissolved
  - Buprenorphine is not well absorbed orally
  - Swallowing will result in reduction of dose/effect
- Buprenorphine/naloxone should not be initiated until patient is in mild withdrawal
- Risk of respiratory depression when used in combination (benzos, alcohol, etc.)

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Counseling Points for Naltrexone

- Wait at least 7 to 10 days after discontinuing opioids to prevent inducing opioid withdrawal
  - May need to wait 14 days with transition from methadone/buprenorphine
- Risk of overdose is increased during waiting period to initiate naltrexone as patient's opioid tolerance may be reduced
- Risk of overdose if using opioids while taking naltrexone
- Wallet card for patient's on long-acting naltrexone

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Wallet Card- Long-Acting Naltrexone

Important Information For Emergency Pain Management

I am currently taking VIVITROL® (naltrexone for extended-release injectable suspension), an opioid antagonist. Please see the back of this card for important information about pain management.

My Name: _____

Emergency contact name: _____

Emergency contact number: _____

My doctor: _____

My doctor's phone number: _____

 VIV-001315 Printed in U.S.A.

Call 1-888-235-8008

For Prescribing Information and Medication Guide, please visit vivitrolsafety.com

Vivitrol®

(naltrexone for extended-release injectable suspension)

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For Prescribing Information and Medication Guide, please visit vivitrolsafety.com

Vivitrol®

(naltrexone for extended-release injectable suspension)

Date of last injection: __/__/__ __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

- The patient is taking VIVITROL, an opioid inhibitor.
- Suggestions for pain management include regional analgesia or use of non-opioid analgesics.
- If opioid therapy is required, it should be administered by healthcare providers specifically trained in the use of anesthetic drugs and management of respiratory effects of potent opioids, specifically the establishment and maintenance of a patent airway and assisted ventilation.
- The patient should be monitored closely in a setting equipped and staffed for cardiopulmonary resuscitation.

To Medical Personnel Treating Me In An Emergency

Emergency Pain Management Card. Available at: https://www.vivitrol.com/content/pdfs/emergency-pain-management-card.pdf

SBIRT

- Screening, Brief Intervention, Referral to Treatment
- Pharmacist- highly accessible healthcare provider
  - Patient encounters 1.5-10 times more than PCP
  - Opportunity for intervention
  - One study in North Dakota found 30% of individuals screened by the pharmacist were at a high risk for overdose
- Resource list
  - Identification of buprenorphine prescribers
  - Local substance use treatment referral programs
  - Screening tools
  - PCP, self-help groups, employee assistance programs

Image Accessed: https://www.samhsa.gov/sbirt

Roestenburg S and Wadhwani A. Incorporating routine screening for substance use disorders in patient visits. *The CPNP Perspective*. Nov 2021.
Bach P and Hartung D. *Addict Sci Clin* 2019;30.
Screening, Brief Intervention, Referral to Treatment (SBIRT) (2022). Retrieved May 23, 2022 from samhsa.gov/sbirt.

SBIRT- Helpful Resources

1. SAMHSA behaviors health treatment services locator (which includes substance use disorder treatment): National Helpline 1-800-662-HELP (4357), https://findtreatment.samhsa.gov/
2. SAMHSA buprenorphine treatment physician locator: http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator/
3. SAMHSA opioid treatment program directory: http://dpt2.samhsa.gov/treatment/directory.aspx
4. National Institute on Drug Abuse http://www.nida.nih.gov
5. Risk assessment tools http://www.opioidrisk.com/node/774
6. VIGIL helps pharmacists screen controlled substances https://www.pharmacist.com/vigil-helps-pharmacists-screen-controlled-substances
7. A pharmacist's corresponding responsibilities and red flags of diversion http://deachronicles.quarles.com/2013/08/a-pharmacists-obligation-corresponding-responsibility-and-red-flags-of-diversion/; http://www.deadiversion.usdoj.gov/pubs/brochures/pharmguide.htm
8. ER/LA opioid analgesics REMS: The extended-release and long-acting opioid analgesics risk evaluation and mitigation strategy http://www.er-la-opioidrems.com/lwgUI/rems/home.action

Screening, Brief Intervention, Referral to Treatment (SBIRT) (2022). Retrieved May 23, 2022 from samhsa.gov/sbirt.

Clinical Pharmacy Services

- Pilot Study- provide clinical pharmacy services in Adult Addictions Clinic at Eskenazi Health
  - Medication reconciliation
  - Patient and family education
  - New medication education to staff
  - Secure funding for medications
  - Drug information questions
  - Adherence Counseling
  - Collaborative practice agreement
    - Up-titration of medications
    - Co-morbid psychiatric medications

Evidence Supporting Clinical Pharmacist

- Study evaluated a pharmacist working 1 day per week in clinic treating individuals with OUD
  - Estimated annualized cost savings of 110,000 dollars
  - Program demonstrated 91% attendance rate, 100% 6 month retention rate, 73% 12 month retention rate
  - 98% of urine screens positive for buprenorphine and 88% were positive for buprenorphine and negative for opioids

DiPaula BA and Menachery E. Physician–pharmacist collaborative care model for buprenorphine-maintained opioid-dependent patients. *J Am Pharm Assoc* 2015; 55: 187-192.

Evidence Supporting Clinical Pharmacist

- 2021 feasibility study transitioned maintenance appointments for 71 patients maintained on buprenorphine treatment for OUD from physician to clinical pharmacist
  - 88.7% of patents were retained in treatment
  - 95.3% buprenorphine adherence rates
  - 4.9% of UDS were opioid-positive
- Satisfaction survey
  - 98.4% rated their satisfaction as satisfied (7.9%) or very satisfied (90.5%) with the quality of treatment offered by the study
  - 96.8% reported that treatment transfer to pharmacist care was not difficult at all
  - 100% of the pharmacists and physicians involved in the study reported being very satisfied with their overall experience in this study
  - 100% of the pharmacists and physicians involved in the study were either very satisfied (91.7%) or satisfied (8.3%) with the quality of treatment offered in this study

Wu LT, John WS, Ghitza UE, et al. Buprenorphine physician–pharmacist collaboration in the management of patients with opioid use disorder: results from a multisite study of the National Drug Abuse Treatment Clinical Trials Network. *Society for the Study of Addiction* 2021; doi:10.1111/add.15353.

Evidence Supporting Clinical Pharmacist

- Pilot study to establish collaborative practice agreement in a primary care setting for patients with OUD
  - Clinical pharmacist was responsible for initial evaluations, buprenorphine inductions, and follow-up visits
  - Pharmacist titrated buprenorphine doses collaboratively with a supervising psychiatrist based on opioid cravings, illicit opioid use, UDS, and pain scores
  - Clinical endpoints indicate treatment retention and aberrant urine toxicology did not differ between clinical pharmacist and psychiatrist

Dimitropoulos E, Bertucci S, and Wong K. Integration of a clinical pharmacy specialist into a substance use disorder intensive outpatient treatment program to improve prescribing rates of alcohol use disorder pharmacotherapy. *Substance Abuse Journal* 2018; 39(2): 1-4.

Business Plan

- Clinical Measures- validated tool that assigns dollar value to pharmacist interventions
  - 62 patient interventions made in 10 days- annualized cost savings ~$200,000
    - Inhaler causing thrush
    - Long acting inhaler prn instead maintenance
    - Patient drinking orange juice when blood sugars high- 2 DKA admissions in one year
    - Metabolic lab monitoring
- Minimize number of medication fees waived
  - Annualized ~$14,000
- Decrease medication errors
  - 1 error caught in 10 clinic days
  - Average med error-~$2,000 with annualized savings ~$57,000
- Billing revenue
  - Estimated around 300,000 dollars of annual revenue generation

Summary

- Work as a physician extender
- Assess/encourage patient adherence
- Counsel on medications
- Expand naloxone access and encourage other harm reduction strategies
- Screen, Intervene, and Refer to Treatment
- Clinical Pharmacy Services in Adult Addiction Clinics