NBPDP
Drug Utilization Review Process Update

The New Brunswick Prescription Drug Program (NBPDP) employs a Drug Utilization Review (DUR) process which identifies, investigates and attempts to deter cases of abnormal narcotic, controlled and benzodiazepine drug usage which may result in abuse or inappropriate use of the program.

The DUR process examines paid prescription claims for NBPDP beneficiaries. Currently, if warranted, based upon the DUR process and feedback from prescribers and pharmacists, NBPDP beneficiaries may be restricted to one physician and one pharmacy for prescription drugs reimbursed by NBPDP. In addition, individuals receiving methadone maintenance therapy for opioid addiction are subject to the same restriction process.

This bulletin is to provide notification that new changes will allow NBPDP to place restrictions on prescriptions for narcotics (including methadone), controlled drugs and benzodiazepines exclusively, so that individuals will have improved access to other classes of medications (e.g. a prescription for an antibiotic from an after-hours or weekend clinic will be reimbursed). This change is effective December 15, 2010 and will also apply to all individuals with restrictions currently in place.

Attachment A provides some additional information and a summary of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain that you may find useful as a resource.

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If you have any questions, please contact our office at 1-800-332-3691.

Yours truly,

Debbie LeBlanc
New Brunswick Prescription Drug Program
Attachment A

**Opioid Use Trends and Summary of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: Information for Healthcare Providers**

By Melissa Hawkins, BSc (Pharm), and Heidi L. Liston, BSc (Pharm) PharmD

**Trends in Opioid Use:**

In Canada, the use of prescription opioid analgesics is rising, with an approximate 50% increase between 2000 and 2004.\(^1\) Accompanying this increase in opioid prescribing, there has been an increase in abuse, serious injuries and overdose deaths among patients treated with opioids. At the same time, it is important to recognize that opioid analgesics have an essential role and can be used safely and effectively in the treatment of many acute and chronic pain conditions.\(^2\)

Over the period of 2004-2010 the number of prescriptions paid through the New Brunswick Prescription Drug Program (NBPDP) continued to increase for opioids including oxycodone, morphine, and hydromorphone. Codeine and combination products realized a slight decline. The cost to the NBPDP for opioids has increased from $2.3 Million in 2004-2005 to $3.4 Million in 2009-2010. Over the same time period, the number of NBPDP beneficiaries receiving methadone maintenance therapy for opioid addiction increased nearly 7-fold with just over 1400 individuals in the 2009-2010 fiscal year. This may in part be due to the removal of the requirement for concomitant cognitive therapy/counselling, however, this alone cannot account for the magnitude in increase. The cost to the NBPDP for methadone maintenance has increased significantly from $442,685 in 2004-2005 to $4.6 Million in 2009-2010. See Graph 1 and 2 for the number of opioid and methadone maintenance prescriptions over time. The number of prescriptions paid through NBPDP for benzodiazepines also continues to increase with the average number of prescriptions per beneficiary now over 8, up from just over 6 in 2004-2005.

![Graph 1. Number of NBPDP Opioid and Codeine Prescriptions by Year](attachment:Graph1.png)
Summary of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain:

There are growing public safety concerns surrounding the misuse of narcotic, controlled and benzodiazepine drugs. This, along with physician sought guidance and the lack of evidence-based national guidelines for opioid use in chronic non-cancer pain (CNCP), prompted Canadian medical regulatory authorities to form the National Opioid Use Guideline Group (NOUGG). CNCP affects many Canadians, and in one study was reported in 27% of seniors living at home.\(^3\) Opioids can be an effective treatment option for many CNCP-causing conditions. The Canadian Guideline for Safe and Effective Use of Opioids in CNCP was recently published in April 2010 by NOUGG.\(^2\)

Concepts emphasized in the Canadian guideline include the use of prescribing agreements (i.e. limiting patients to one physician and one pharmacy), diligent monitoring for aberrant drug-related behavior, and collaboration with pharmacists who may be able to identify inappropriate drug use. The New Brunswick Prescription Drug Program (NBPDP), Drug Utilization Review (DUR) process can serve as a support tool for prescribers and pharmacists to be able to implement some of the guideline recommendations and to identify NBPDP beneficiaries who may be at risk of opioid misuse.

The three groups involved in the development of the Canadian guideline were the NOUGG, a Research Group, and a National Advisory Panel. The role of the NOUGG was to manage and oversee the development and implementation of the final guideline. The tasks of the Research Group were literature review, critical appraisal and summary of the evidence, generation of the first draft and revision of recommendations once they received feedback from the National Advisory Panel. The National Advisory Panel included physicians, other health care professionals, and patients with CNCP. Their responsibility was to comment and reach consensus on recommendations for the guideline. The guideline was supported by medical regulatory authorities; however, it is intended to serve as a tool to support clinical decision making, not as a standard of practice.
There is a paucity of supporting evidence addressing opioid use for CNCP. Therefore, it is important to recognize that the recommendations included in the Canadian guideline are heavily based on expert opinion and consensus of the National Advisory Panel. Only 62 of the 184 studies used were randomized trials, the remainder being observational studies. The studies generally had short follow-up periods and did not measure some important functional outcomes such as return to work, cognitive impairment, and productivity. The guideline only addresses opioid use and does not discuss other pharmacologic and non-pharmacologic treatment options in CNCP. The scope of the guideline is limited to CNCP, and does not incorporate pain of other types (acute, palliative or chronic cancer pain).

The guideline is divided into 5 clusters of recommendations accompanied by a discussion and a summary of reviewed supporting evidence. The clusters follow a continuum along the treatment pathway: deciding to initiate opioid therapy, conducting an opioid trial, monitoring long-term opioid therapy, treating specific populations with long-term opioid therapy, and managing opioid misuse and addiction in patients with chronic pain. Key recommendations along with select tools for implementation provided in the guideline document are summarized below.

**Recommendations**

**Cluster 1 – Deciding to Initiate Opioid Therapy:**

**Comprehensive patient assessment** – Ensure thorough assessment and documentation of the patient’s pain condition, medical and psychosocial history, psychiatric status and substance use history.
- Available tools: Guidance for comprehensive assessment, interview tools to assess alcohol consumption and substance use.

**Addiction risk screening** – Consider using a screening tool to determine the patient’s risk of opioid addiction. Many of the tools available are not well studied or validated, but the Opioid Risk Tool (ORT) is widely used.
- Available tools: ORT

**Urine drug screening (UDS)** – UDS can be used to establish a baseline measure of risk or monitor compliance. Be aware of benefits, limitations, appropriate ordering and interpretation.
- Available tools: Patient education tools, point-of-care vs. laboratory testing comparison, information for interpretation of results.

**Opioid efficacy** – Consider the evidence for opioid effectiveness for the patient’s CNCP-causing condition. Medium effect sizes for pain reduction have been shown for nociceptive pain of musculoskeletal origin (e.g. osteoarthritis, low back pain, etc.) and neuropathic pain. Small effect sizes for functional improvement have been shown for the same conditions.
- Available tools: Summaries of randomized trials and examples of conditions where opioids have been shown to be effective.

**Informed consent** – Review potential benefits, risks, adverse effects, and complications of opioid therapy with the patient. Goal setting and a treatment agreement may be helpful.
- Available tools: Summary of opioid benefits, risks and complications, patient education tool, and sample treatment agreement.
**Benzodiazepine Tapering** – Consider tapering benzodiazepines as their concomitant use with opioids may increase the risk of sedation, overdose and diminished function, especially in the elderly.

- Available tools: Benzodiazepine tapering protocol

**Cluster 2 – Conducting an Opioid Trial:**

**Dose titration and driving** – advise patients to avoid driving during dose titration until a dose that is stable and is not causing sedation is established.

**Stepped opioid selection** – During an opioid trial, select the most appropriate opioid agent using a stepped approach.

- Available tools: Guide for opioid selection and table highlighting safety issues for specific agents

![Opioid Selection Table]

**Optimal dose** – Start with a low opioid dose, increase slowly while monitoring for analgesic efficacy and adverse effects.

- Available tools: Table of suggested initial dosage and titration schedules

**Watchful dose** – CNCP can typically be managed effectively with doses at or below 200mg/day of morphine or equivalent. Higher doses warrant re-evaluation.

**Risk of opioid misuse** – In patients who are at a higher risk of misuse, monitor closely for signs of aberrant drug-related behavior. Indicators of patients at higher risk include 1) a history of alcohol or substance abuse, 2) uncertain security in home, and 3) past aberrant drug-related behaviors.

- Available tools: Tool for detecting aberrant drug-related behaviors, guidance on titration and monitoring in patients at higher risk.

**Cluster 3 – Monitoring Long-Term Opioid Therapy:**

**Monitoring** – Monitor for opioid effectiveness, adverse effects and other complications, and aberrant drug-related behaviors. Physician-pharmacist collaboration can facilitate patient monitoring.

- Available tools: Information on monitoring elements, monitoring tools, example of an opioid therapy record.
Switching or discontinuing opioids – If patients are experiencing unacceptable adverse effects or lack of effectiveness on one agent, try prescribing a different opioid agent or discontinuing therapy and reassessing.

- Guidance on dosing when switching agents, protocol for tapering opioids, opioid conversion table.

Long-term therapy and driving – Factors that could impair driving in patients on long-term opioid therapy include consistent severe pain, disordered sleep patterns, and concomitant medications that could cause sedation

Revisiting steps of opioid trial therapy – For patients who have been treated with opioids for an extended period and who had not initially progressed through an appropriate trial of therapy, follow-up is recommended. Ensure that the following have been addressed: pain condition diagnosis, risk screening, goal setting, informed consent, appropriateness of dose, opioid effectiveness.

Collaborative care – Consultations with physicians with expertise in pain management or addiction, referral for treatment interventions and shared-care models may be useful in managing patients with CNCP. Effective communication between primary-care physicians and consultants is essential for seamless care and safe and effective treatment with opioids.

Cluster 4 – Treating Specific Populations with Long-Term Opioid Therapy:

Elderly patients – Precautions to be taken in elderly patients being treated with opioids include lower starting doses, slower dose titration, longer dosing interval, more frequent follow-up and monitoring and tapering of benzodiazepines if appropriate. Oral oxycodone or hydromorphone may be preferred over morphine.

- Available tools: description of risks of opioid therapy in the elderly, benzodiazepine tapering protocol.

Adolescent patients – Misuse of opioids is more common in adolescents and may be a risk factor for future opioid addiction. Risk factors for misuse include poor academic performance, higher risk-taking behaviors, major depressions, and regular use of alcohol, cannabis and nicotine. In adolescent patients with CNCP with a clear indication for opioid therapy and who have failed other treatment options, titrate dose more slowly, avoid commonly abused opioids, and have a structured treatment plan.

Pregnant patients – Pregnant women on long-term opioid therapy should be tapered slowly to the lowest effective dose, avoiding withdrawal symptoms, then therapy should be discontinued if possible. Tramadol is not recommended in pregnancy and the safety of fentanyl is not established. Pregnant patients with an opioid addiction should be treated with methadone.

- Available tools: description of postpartum precautions

Patients with a co-morbid psychiatric diagnosis – These patients are at a higher risk of substance abuse, sedation and falls, overdose, and depression. Treatment should usually be reserved for well defined CNCP conditions with evidence for opioid effectiveness. Doses should be titrated more slowly and patients should be monitored frequently.
Cluster 5 – Managing Opioid Misuse and Addiction in CNCP Patients:

Opioid addiction in patients with CNCP has an estimated prevalence of 3.3%

Options for addiction treatment – Options include methadone or buprenorphine treatment programs, structured opioid therapy, abstinence-based treatment.
  o Available tools: Indications and descriptions of treatment options.

Prescription fraud – Physicians should take precautions to avoid prescription fraud. For example, faxing prescriptions, using carbon copies, keeping prescription pads secure and working collaboratively with pharmacists.

Unacceptable patient behavior – Have an approach to dealing with patients who disagree with prescriptions or who display unacceptable behavior. Be aware of obligations to the patient, staff and society if illegal patient activities are suspected.

Acute care opioid prescribing policy – Acute health care facilities (e.g. emergency departments) should be equipped to appropriately respond to patients with chronic pain and to patients who are seeking opioids for misuse or diversion.

References:

For complete recommendations, practice tools and more information, the full Canadian Guideline for Safe and Effective Use of Opioids for CNCP is available at http://nationalpaincentre.mcmaster.ca/opioid. The Michael G. DeGroote National Pain Centre at McMaster University has taken on the responsibility of keeping the guideline up-to-date as new supporting evidence becomes available.