tipSC | Timely Information for Providers in South Carolina

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

MARCH 2024

SCRIPTS Tips for Pharmacists

Optimizing Data Entry and Clinical Use

https://www.schealthviz.sc.edu/tipsc-1

TO CREATE A PATIENT REQUEST GO TO: *http://southcarolina.pmpaware.net*

- Click <MENU>, then <PATIENT REQUEST>
- Input required fields: FIRST NAME, LAST NAME, DOB (mm/dd/yyyy)
- Scroll down and click <SEARCH>

TO QUICKLY VIEW A REPORT

Patient, Test, 33F Refine Search
Date of Birth: 10/24/1988 Recent Address: View Linked Records (3)

SCROLL DOWN TO SEE THE FOLLOWING SECTIONS

Integrated Patient Records
Total (3)

Review naloxone administration details reported by first responders and major healthcare facilities

Incident Date	Medication Given	Dosage	Administered By	Zip code of Administration
12/12/2021	Naloxone (Narcan)	1 mg	University Hospital	29401
12/12/2021	Naloxone	1 Each	EMS	29407
06/20/2021	Naloxone	1 Each	EMS	29407

Prescriptions

Review controlled substances (CII-CIV) dispensed to patient (default displays 2 years)

08/22/2018	08/22/2018	3	Tramadol Hcl 50 Mg Tablet	60.00	30	Te Doc	20180822	App (1119)	0/0	10.00 MME	Private Pay	SC
04/15/2017	02/15/2017	2	Alprazolam 0.5 Mg Tablet	100.00	7	Bo Tes	305860	Gut (1119)	2/2	14.29 LME	Comm Ins	SC
03/15/2017	02/15/2017	2	Alprazolam 0.5 Mg Tablet	100.00	7	Bo Tes	305860	Gut (1119)	1/2	14.29 LME	Comm Ins	SC
03/15/2017	02/15/2017	2	Oxycodone-Acetaminophen 5-325	100.00	7	Bo Tes	305862	Gut (1119)	1/0	107.14 MME	Comm Ins	SC
02/15/2017	02/15/2017	2	Alprazolam 0.5 M			Bo Tes	305860	Gut (1119)	0/2	14.29 LME	Comm Ins	SC
02/15/2017	02/15/2017	2	Oxycodone-Aceta			Bo Tes	305861	Gut (1119)	1/0	107.14 MME	Comm Ins	SC
02/02/2017	02/01/2017	1	Oxycodone-Aceta			Da Tes	4455	Dav (0000)	0/0	15.00 MME	Comm Ins	SC
01/26/2017	01/26/2017	1	Oxycodone Hcl (			Al Tes	3344	Car (8506)				SC
12/26/2016	12/26/2016	1	Oxycodone Hcl (			Al Tes	2233	Car (8506)				SC
11/26/2016	11/26/2016	1	Oxycontin Er 80 M			Ca Tes	1122	Car (5555)				SC
10/31/2016	10/31/2016	1	Oxycodone-Acetaminophen 5-325	60.00	30	Da Tes	5566	Dav (0000)				SC

Disclaimer

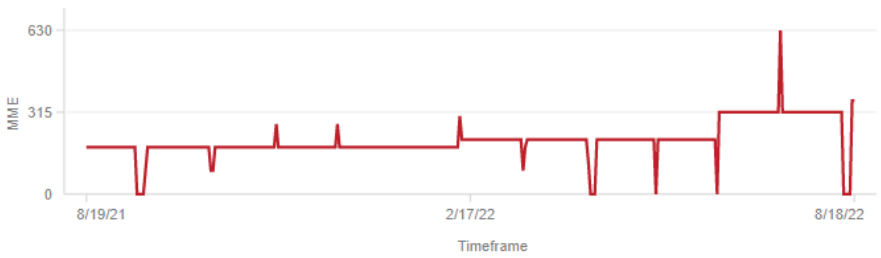
Data entry impacts SCRIPTS Narx reports; flip to backside for quick tips

Review calculated Morphine Milligram Equivalent (MME) per day for each individual prescription

Morphine Milligram Equivalent Prescribed Over Time

Last 30 Days | Last 60 Days | Last 90 Days | Last 1 Year | Last 2 Years

Click desired time frame to view MME per day over time (*default is last 30 days*)



206.3
MME per Day Avg.

2,896.2
MME per RX

CONSIDERATIONS FOR REVIEWING SOUTH CAROLINA PRESCRIPTION

A SCRIPTS Narx Report (also called a DHEC or PMP report) is one tool to help review and

WHAT IF:

APPARENTLY GOOD RESULTS (1 PHARMACY, 1 OPIOID PRESCRIBER)[1]

- Does it match patient profile and personal presentation in the pharmacy (e.g., interactions, conversations)?
- Consider non-adherence behaviors not captured in results (e.g., binging, running out early).

WHAT IF:

TOTAL MORPHINE MILLIGRAM EQUIVALENTS PER DAY (MME/day)[2] SUGGESTS CONCERN FOR ADVERSE EVENTS OR OVERDOSE[3,4]

- More recent guidelines recommend additional precautions when prescribing ≥ 50 MME/day including offering naloxone[4,5] along with overdose prevention education to patients and caregivers.
- For patients already on higher opioid daily doses, risks and benefits of continuing or tapering opioid dose must be carefully weighed. Guidelines do not recommend abrupt tapering or discontinuation of opioids.

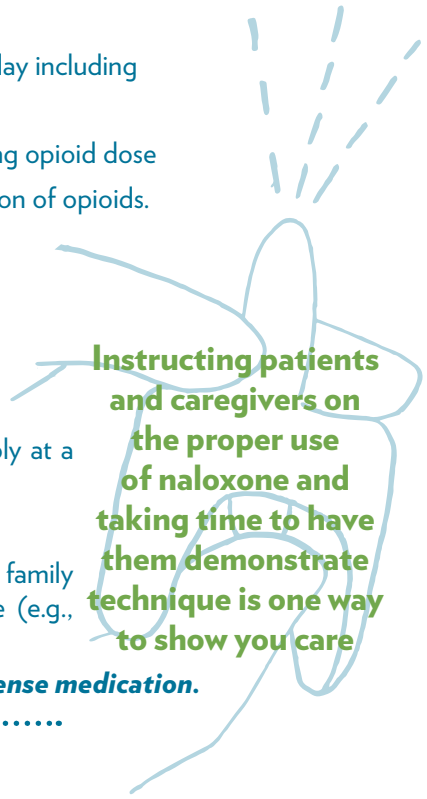
All homes that contain opioids carry some risk of overdose for the patient and others.

WHAT IF:

OVERDOSE RISK SCORE (ORS)[6] SUGGESTS CONCERN FOR ADVERSE EVENTS OR OVERDOSE

- ORS indicates the risk of unintentional overdose death; the odds begin to increase sharply at a score of 200.[6]
- Look at the list of *Key Contributing Factors*[7] to help identify potential patient risks.
- Use the ORS[7] as a signal to review the complete patient profile and speak with patient and family to identify factors not captured in SCRIPTS that can influence unintentional overdose (e.g., depression, respiratory conditions).

The ORS alone is NOT sufficient information to decide to dispense or refuse to dispense medication.



Instructing patients and caregivers on the proper use of naloxone and taking time to have them demonstrate technique is one way to show you care

WHAT IF:

COMBINATION OF OPIOID AND OTHER CONTROLLED SUBSTANCE(S), ESPECIALLY BENZODIAZEPINES[8,9]

- Pain guidelines concur benzodiazepines and opioids are high risk combinations, especially in the elderly; many recommend against combination unless clearly indicated.
- Encourage patients to make sure all providers know they are on an opioid AND benzodiazepine; it is important for providers to monitor for respiratory depression if the benefits of the combination outweighs the risk.
- Check and offer naloxone[4,5] along with overdose prevention education.

For more information on tapering opioids and/or benzodiazepines visit: https://bit.ly/opioids_benzos

WHAT IF:

OPIOID-ACETAMINOPHEN COMBINATION PRODUCT

- Counsel patient on risk of exceeding 4000 mg total daily acetaminophen dose. Consider 3000 mg total daily dose, especially if elevated liver function tests, known liver impairment, or older age; limit use to 2000 mg total daily dose in patients with alcohol use disorder or taking warfarin.
- Counsel patient to avoid alcohol and medications with alcohol (e.g., cough syrups) when taking acetaminophen unless provider has given different instructions.
- Remind patients about "hidden" acetaminophen and alcohol found in some medications and over-the-counter (OTC) allergy, cold, and sleep products (e.g., night time pain relievers).

MONITORING PROGRAM (SCRIPTS) NARX REPORTS

confirm a patient's controlled substance (CII – CIV) medication use and history

WHAT IF:

POTENTIAL ABERRANT BEHAVIOR (2 OR MORE PHARMACIES, 2 OR MORE OPIOID PRESCRIBERS)[3]

- Does it match patient interactions with you and staff or feedback from patient, family, and friends?
- Recognize the multiple reasons for possible inappropriate opioid use:

☐ **ADDICTION** - often characterized by behaviors that may include loss of control over drug use, craving, compulsive use, and continued use despite harm to health or relationships (See table at right)

Physical dependence and tolerance are normal physiologic adaptations to extended opioid therapy and are NOT the same as addiction.

☐ **PHYSICAL DEPENDENCE** - biologic adaptation to drug that results in abstinence syndrome (signs and symptoms of withdrawal) upon cessation, rapid dose reduction and/or administration of antagonist

☐ **TOLERANCE** - a physiologic state of reduced effect over time from regular drug exposure in which increased dosage is needed to produce specific effect (*increase in dose and no increase in effect may mean opioid is ineffective*)

☐ **HYPERALGESIA** - increase in pain sensitivity that can be seen with rapid opioid dose escalation or high opioid dose (*consider if increase in pain with increase in dose*)

☐ **PSEUDO-ADDICTION** - aberrant drug-related behaviors driven by uncontrolled pain (*relief seeking vs drug seeking*) that are reduced by improved pain control

☐ **OTHER PSYCHIATRIC ILLNESSES** - such as anxiety, depression, PTSD, "chemical coping" (knowingly or unknowingly taking medications to decrease or numb negative emotions)

☐ **DIVERSION** - moving medications from legal/medically indicated users to illegal/unauthorized users

CONCERNING BEHAVIORS FOR ADDICTION
○ Requests for increases in opioid dose
○ Requests for specific opioid by name, "brand name only" or allergic to all but the desired opioid
○ Overwhelming focus on opioids during visits instead of underlying disease process
○ Multiple office contacts regarding opioids
○ Unwilling to follow through with recommended therapy/referrals (e.g., physical therapy)
○ Running out early due to unsanctioned dose escalation
○ Resistance to change therapy despite harm or negative consequences (e.g., over-sedation); unwilling to consider non-opioid therapy
○ Concurrent alcohol or substance abuse
○ Deterioration in function at home and work
○ Opposition to monitoring (e.g., pill counts, UDT)
○ Three or more requests for early refills
○ Multiple "lost," "spilled," or "stolen" opioid prescriptions
○ Multiple sources for opioids
○ Illegal activities – forging prescriptions, selling opioid prescriptions
○ Overdose

Adapted with permission: Boston University SCOPE of Pain Program www.scopeofpain.com

Familiarity with educating patients about use of naloxone[5] can put you and the patient more at ease and potentially improve communication and outcomes (just like with inhalers and other medical devices).

Consider sharing that:

- "Prescribing naloxone is like prescribing epinephrine (Epi-pen®) to someone with a food allergy."
- "It is there to keep you safe in case something accidentally happens."
- "Naloxone is like a fire extinguisher. It is there to keep you and your family safe."

For more information about naloxone, including formulation-specific administration instructions, go to http://opirescue.com/rescue

[1] Not all dispensed opioids require reporting to SCRIPTS, such as methadone dispensed from Opioid Treatment Programs (i.e., 'methadone clinics') or < 48-hour supply from emergency department.
[2] Morphine Milligram Equivalents (MME) is a mathematical conversion that standardizes risk evaluation of the different opioids.
[3] Increased risk of opioid overdose-related death has been associated with 4+ opioid prescriptions, 4+ pharmacies, or total MME/day ≥ 100.
[4] Multiple guidelines agree on co-prescribing naloxone to anyone currently on chronic opioids in ANY ONE of the following higher risk groups: opioid dose ≥ 50 MME/day; concomitant benzodiazepine and opioid use; history of opioid overdose or substance use disorder; respiratory conditions (e.g., COPD, sleep apnea); mental health condition(s); excessive alcohol use; AND previously on chronic opioids with a lost tolerance to previous dose and at risk of resuming that dose using prescription or illicit drugs (e.g., opioid taper underway, recent release from prison or detoxification facility).
[5] Multiple formulations and dosages of opioid overdose antidotes (e.g., naloxone, nalmefene) are now available; evidence suggests high-dose version of naloxone (8 mg) does not improve survival rates compared to 4 mg.
[6] An ORS of 000 is an error reading meaning no ORS could be calculated.
[7] *Key Contributing Factors* displayed and used in the ORS calculation include: greater than 6 opioid prescriptions dispensed; benzodiazepine-narcotics overlap; # of high-risk prescriptions dispensed; # of pharmacies where opioids/sedatives dispensed; total days supply of short-acting opioid prescriptions; and # of overlapping opioid/sedative dispensations.
[8] Benzodiazepines and opioid medication labelings carry black box warnings highlighting the risks associated with concomitant use.
[9] Lorazepam Milligram Equivalent (LME) values in SCRIPTS offer one way to compare sedative hypnotic medications for dose-related risk considerations.

DATA ENTRY TIPS THAT MAY IMPROVE SCRIPTS NARX REPORTS

Data entry impacts SCRIPTS Narx reports for everyone – affecting timely refills and the ability to identify clinical concerns.

Basic suggestions to prevent multiple patient records for the same patient are to carefully enter:

- ✓ Legal FIRST and LAST NAME as it appears on driver's license (avoid nicknames and middle names)
- ✓ Date of Birth
- ✓ FULL Address (utilize United States postal service [USPS] address standards to help minimize creation of multiple PMP records for an individual patient). To look up USPS approved abbreviations, go to https://pe.usps.com/text/pub28/28c2_001.htm
- ✓ AVOID special characters (to help minimize data rejection or creation of multiple records for an individual patient)

Other suggestions to help minimize issues with refills and evaluating SCRIPTS Narx reports are to be mindful of:

- ✓ "Days Supply" especially for as-needed prescriptions (can affect calculated daily MMEs, refill dates, and patient care)
- ✓ "Fill Date" (can potentially affect timing for refills)

Appreciate that accurate data entry into any field is key; even data entered into non-essential fields may have the potential to affect algorithms and data uploading to SCRIPTS.

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The information contained in this summary is intended to assist pharmacists and pharmacy technicians in the management of chronic non-cancer pain in adults in the primary care setting. This information is advisory only and is not intended to replace sound clinical judgement, nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac, liver and renal impairment; debility; addiction; and pregnancy/breast-feeding).