



Safe Prescribing of Drugs with Potential for Misuse/Diversion

Standards of Practice of the Yukon Medical Council (“the Council”) are the minimum standards of professional behavior and ethical conduct expected of all physicians registered in the Yukon. Standards of Practice will be referenced in the management of complaints and in discipline.

Preamble

This document establishes both professional standards as well as guidelines of the Yukon Medical Council (YMC).

A standard reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the YMC of all physicians in Yukon. **A guideline** reflects a recommended course of action established based on the values, principles and duties of the medical profession. Physicians may exercise reasonable discretion in their decision to act on the guidance provided, but should support a decision to follow a different action with a comprehensively documented rationale.

YMC’s Position

The public health crisis of prescription drug misuse has developed in part due to the prescribing of physicians. The profession has a collective ethical responsibility to mitigate its contribution to the problem of prescription drug misuse, particularly the over-prescribing of opioids, sedatives and stimulants.

The YMC acknowledges the appropriate role of pharmacotherapy in the context of active cancer, palliative, nursing home and end-of-life care. These standards may not apply to the treatment of patients in these situations.

Every physician is professionally responsible for the prescription that they provide to a patient.

Long-term opioid treatment (LTOT) refers to the prescribing of daily opioid medications on a continuous, and not as-required, schedule.

Standards

Physicians **must**:

1. Review patients’ current medications (using Yukon’s Drug Information System profiles when access is available) before prescribing opioids, sedatives or stimulants. (Additionally, physicians may want to contact a patient’s pharmacy to reconcile the patient’s medication profile.)
2. Base long-term treatment with medications with known risks, including opioids, sedatives and stimulants, upon a clinical diagnosis and objective evidence. Continuing to prescribe medication solely on the basis that they have been previously prescribed is not acceptable.

Terms used in the Standards of Practice:

- *Physician* means any person who is registered or who is required to be registered under the Medical Profession Act.
- *Must* refers to a mandatory requirement.
- *May* means that the physician may exercise reasonable discretion.
- *Patient* includes, where applicable, the patient’s legal guardian or substitute decision maker.

3. Document discussion with patients that non-pharmacologic therapy and non-opioid analgesics are preferred for chronic non-cancer pain (CNCP) and that potential benefit of LTOT is modest and risk significant.
4. Advise patients that LTOT is not indicated for certain medical conditions including headache disorders, fibromyalgia and axial low back pain.
5. Always prescribe the lowest effective dosage of opioid medication. Doses >50 morphine milligram equivalents (MME) per day warrant careful reassessment and documentation. Doses >90 MME per day warrant substantive evidence of exceptional need and benefit. (This advice excludes treatment with methadone.)
6. When treating patients with acute pain conditions, prescribe only immediate release opioids in quantities that the patient will need before community follow-up will be resumed (three to seven days is often adequate).
7. When discharging patients from acute-care settings, or post-operatively, prescribe only the quantities of opioids, sedatives or stimulants that the patient will need before community follow-up will be resumed.
8. Base decisions to prescribe long-term psychoactive medications, including LTOT, on well-documented, comprehensive initial assessments and frequent (at least every three months) reassessments. These assessments and reassessments must include documented history and physical examination of the patient. There must also be documentation that the patient has been screened regularly for the presence or emergence of mental health and substance use disorders and risk factors and advised about safety-sensitive occupational risks, child care responsibilities and driving.
9. Document having directed and regularly reminded patients for whom they are prescribing LTOT to abstain from alcohol and non-prescription sedatives.
10. Order at least annual random urine drug testing (rUDT) and/or random pill counts for all adult patients on long-term opioids, benzodiazepines, sedative hypnotics or stimulants.
11. Inform the patient about naloxone and the availability of take-home naloxone kit from their pharmacist.

Further, physicians **must not**:

12. Prescribe benzodiazepines or other sedative hypnotics to patients on LTOT, other than as a documented taper*.
13. Prescribe combinations of*:
 - opioids with benzodiazepines and/or sedative hypnotics
 - stimulants with benzodiazepines and/or sedative hypnotics
14. Provide prescriptions allowing dispenses of opioids, sedatives and stimulants, which exceed a three-month supply or 250 tablets, whichever is less.
15. Initiate treatment with drugs with a high risk-profile such as methadone and fentanyl without relevant training and experience.

* Exceptions may apply with caution and frequent reassessment of indications.

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Guidelines

1. Physicians who prescribe opioids, sedatives or stimulants will be expected in the future to have Drug Information System access in all clinical locations and to use it appropriately. In situations where Drug Information System access is not currently available, physicians are expected to consult colleagues, including pharmacists, and prescribe only necessary medications until the patient's dispensing history is available. (Walk-in, multi-physician clinics and methadone clinics must have on-site access to Drug Information System when available.)
2. If starting opioid therapy for chronic non-cancer pain (CNCP) physicians should prescribe immediate release (IR) opioids only. Extended release (ER), long-acting (LA) and opiate transdermal patch preparations should not be prescribed for an opioid-naïve patient and should be reserved for patients experiencing severe continuous pain.
3. LTOT should always be described as a trial, to be discontinued if functional improvement cannot be objectively demonstrated or harms emerge. When patients have been on LTOT for long periods of time, physicians should perform a comprehensive assessment of the benefits versus the harms of the treatment. Where benefits do not outweigh harms, patients should be empathetically advised that the medication will be tapered to a lower dose or to discontinuation. It is rarely appropriate to abruptly discontinue LTOT and opioid tapering protocols should be slow enough to minimize symptoms of withdrawal (a 10% dose reduction every one to two weeks is considered reasonable). Consultation with the patient's pharmacist may be warranted, especially for patients with complex medication regimens and multiple co-morbidities.
4. LTOT is generally not appropriate for high-risk groups, including patients with addiction, major psychiatric illness or personality disorders, young people, and those with functional somatic syndromes. When patient assessment or reassessment reveals a diagnosis of a substance use disorder or other mental health diagnosis physicians should consider consultation with a physician with experience in addiction medicine and/or a psychiatrist regarding appropriate management.
5. The prevalence of an opioid use disorder may be as high as 26% among primary care patients receiving opioids for CNCP. Patients with a diagnosis of an opioid use disorder should be offered treatment including medication assisted treatment with methadone or buprenorphine, as well as abstinence-based treatment where appropriate. (Please refer to the appropriate YMC Standard/Guideline when indicated.)
6. Other concurrent medical conditions that should be carefully considered in the context of decisions to prescribe or continue LTOT include obesity, congestive heart failure, sleep apnea, chronic lung disease and renal or hepatic insufficiency. Elderly patients are more likely to suffer from these concurrent diagnoses and to be taking multiple medications and suffer from cognitive impairment all of which significantly increase risk.
7. When providing prescriptions for opioids, sedatives or stimulants, consider the possibility that other household members (including young children) might accidentally or deliberately take those medications. Prescription medications, especially opioids, should be securely stored, preferably locked, and unused medications disposed of at a pharmacy.

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8. Tolerance to benzodiazepines and sedative hypnotics may develop quickly. They should be prescribed for short-term use only and not in doses that exceed the manufacturer's recommended maximum.

9. It is recommended that all emergency rooms and multi-physician clinics have a consistent policy around the prescribing (and dispensing) of opioids, sedatives and stimulants.

10. Assessing risks of misuse or diversion based only on patient assessment and self-report without objective contextual information is difficult. Supervised urine drug testing (UDT) may be performed in the office as point-of-care testing or sent to the laboratory, but physicians should understand the results and limitations of the test they are using. Even when risks seem low, random urine drug testing (rUDT) and/or random pill counts can provide important information. The requirement for UDT should be discussed nonjudgmentally at the initiation of the treatment relationship, in order to minimize the perception of stigmatization. (Supervised UDT urine drug testing means a reasonable level of supervision but not necessarily witnessed provision of the sample. Random UDT using a 24-hour phone call protocol is more informative than predictable UDT at the time of a scheduled office visit. Random pill counts are a non-intrusive method of assessing patient compliance.)

11. The advice to avoid concurrent prescribing of opioids and sedative hypnotics such as benzodiazepines is based on the significantly increased risk of overdose death in this patient population. However, physicians should be aware that other central nervous system (CNS) depressants (including muscle relaxants, anticonvulsants, sedating antidepressants, antipsychotics, some over-the-counter medications and alcohol) may also potentiate CNS and respiratory depression. If LTOT is clinically appropriate, benzodiazepines should be tapered and discontinued. Benzodiazepine tapering should be gradual because of the significant risks of benzodiazepine withdrawal.

Other Comments

1. Physicians, when prescribing opiates and other Triplicate Prescription Program medications, must be familiar with the documents "[Methadone Standard of Practice](#)", "[Methadone Authorization Procedure](#)" and "[Triplicate Prescription Program: Information for Physician Prescribers](#)", found on the YMC website Standards of Practice page.

2. Acknowledgements: The Yukon Medical Council wishes to acknowledge and thank the College of Physicians and Surgeons of British Columbia for its support and for partnering with the Council in this standard/guideline.

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