



Executive Summary

Introduction

In March 2013, the Canadian Centre on Substance Abuse (CCSA) released their report *First Do No Harm: Responding to Canada's Prescription Drug Crisis*, which recognizes prescription drug abuse as the nation's "leading public health concern." According to the CCSA, the ready availability of these drugs in Canada, "can have a devastating impact on individuals and their families, as well as place a significant burden on our health, social services, and public safety systems."¹

The purpose of this *Environmental Scan* is to provide an overview of policies, practices, and initiatives which the publicly funded drug programs, colleges of physicians and surgeons, and colleges of pharmacy are implementing across Canada to address the misuse, abuse, and diversion of prescription narcotics (opioids), benzodiazepines, stimulants, and gabapentin. This information may assist drug policy decision-makers, as well as other stakeholders, in understanding the numerous efforts being undertaken across the country in response to the issue of prescription drug abuse, which is compromising the health and safety of Canadians.

The terms "narcotic" and "opioid" are used interchangeably throughout this document. It is noted that some jurisdictions prefer the term "opioid."

Because health systems differ markedly from jurisdiction to jurisdiction, strategies to address

abuse are highly variable. This report outlines many of the leading initiatives across Canada that aim to minimize opportunities for misuse, abuse, and diversion while ensuring access to adequate treatment options.

Objective

The purpose of this report is to outline the policies, initiatives, and practices in place across Canada to address the abuse, misuse, or diversion of prescription narcotics, benzodiazepines, stimulants, and gabapentin.

Methodology

This *Environmental Scan* is not intended to provide a comprehensive review of the topic. Results are based on communication with key expert consultants from 11 of Canada's 19 publicly funded drugs plans, 9 of 10 provincial colleges of physicians and surgeons, 8 of 10 provincial colleges of pharmacists, and the Medical Director of Family Medicine, Northwest Territories. Of the 33 organizations or individuals contacted, responses were received from 30. The report also includes information collected from a web-based search for publicly available information on the Internet as of February 16, 2014.

A limitation with this report is that the survey was restricted to policies, practices and initiatives for public drug plans, physicians and pharmacists; whereas, in Canada, other health care providers such as dentists and nurse practitioners also have the authority to prescribe narcotics and controlled drugs.

Key expert consultants responded to the following survey questions:

1. What prescription-monitoring programs are in place for narcotics, benzodiazepines, stimulants, and gabapentin?
2. Other than narcotics, what drugs are included on monitored drug lists?
3. What key utilization findings informed changes to policies or practices for narcotics, benzodiazepines, stimulants, and gabapentin within the last two years?
4. What prescriber-related policies, practices, or initiatives are in place for narcotics, benzodiazepines, stimulants, and gabapentin?
5. What drug-specific protocols are in place for pharmacists dispensing narcotics, benzodiazepines, stimulants, and gabapentin?
6. Are there any recently adopted or future plans to adopt, new narcotic, benzodiazepine, stimulant, or gabapentin-related policies, practices or initiatives, and what prompted these decisions?
7. Are there any narcotic, benzodiazepine, stimulant, or gabapentin-related policies, practices, or initiatives under consideration by federal, provincial, and territorial (F/P/T) drug plans?
8. Are there any narcotic, benzodiazepine, stimulant, or gabapentin-related educational initiatives under way?
9. What systems are in place to identify forged/illegitimate prescriptions and how are such prescriptions communicated to prescribers and/or pharmacists?
10. Is there a system in place to designate a single pharmacy to dispense a patient's medications if "double-doctoring" practices have been identified for narcotics, benzodiazepines, stimulants, or gabapentin?
11. Are there any systems in place that allow communications between jurisdictions for monitoring prescription use of narcotics, benzodiazepines, stimulants, or gabapentin?
12. What reimbursement policies are in place to manage overuse of narcotics, benzodiazepines, stimulants, or gabapentin?
13. How are limited use/special authorization requests adjudicated, electronically or manually?
14. Is there information captured by F/P/T drug plans on the effectiveness of surveillance programs being led across the country?

Report Structure

All of the above information was synthesized into the report sections that follow. The report is structured into the following initiatives that have been employed by provincial governments, public drug plans, colleges of physicians and surgeons, and colleges of pharmacists to manage prescription narcotics, benzodiazepines, stimulants, and gabapentin:

- Monitoring and Surveillance
 - Programs
 - Program Evaluation
 - Forged, Illegitimate, and Lost Prescription Policies
 - Cross-Jurisdictional Communication
- Drug Plan Limits
- Methadone and Suboxone Prescribing Policies
- Other Initiatives
 - Education
 - Prescriber Profiles
 - Prescriber and Pharmacy Designations

The Summary of Findings is essentially the key information and comparison of policies and practices gleaned from the whole report.

Summary of Findings

Table 1: Pan-Canadian Initiatives to Manage the Use of Prescription Narcotics, Benzodiazepines, Stimulants, and Gabapentin													
Program Element	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NT	NIHB
Prescription-monitoring program in place	Y	Y	Y	Y	Y	N	Y	Y	N	N	Y ^a	N	Y
Monitors for stimulant use	Y	Y	Y	Y	Y	N	Y	Y	N	N	Y	N	Y
Monitors for benzodiazepine use	Y	Y — To begin 2014-2015	Y	Y	Y	N	Y	Y — Fall 2014	N	N	Y — To begin 2014-2015	N	Y
Monitors for gabapentin use	N	N	Y	N	N	N	N	N	N	N	N	N	Y
Cross-jurisdictional communication regarding monitoring practices and/or initiatives	N	N	N	N	N	N	N	N	N	N	NR	N	N
Information captured on surveillance/ monitoring program effectiveness	N	N	N	N	N	NR	N	N	N	N	NR	N	N
Prescriber-oriented educational initiatives	Y	Y	Y	Y	N	Y	Via NBMS	Y	Y	NR	NR	Y	NR
Currently developing monitoring initiatives	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NR	Y	Y
Single-pharmacy designation policy	Y	Y ^b	N	Y	N	Y	Y	Y ^c	Y ^d	N ^e	NR	N	N ^f

AB = Alberta; BC = British Columbia; MB = Manitoba; N = no; NB = New Brunswick; NBMS = New Brunswick Medical Society; NIHB = Non-Insured Health Benefits; NL= Newfoundland and Labrador; NR = not reported; NS = Nova Scotia; NT = Northwest Territories; ON = Ontario; PE = Prince Edward Island; QC = Quebec; SK = Saskatchewan; Y = yes; YT = Yukon.

^a Yukon Territory participates in Alberta’s Triplicate Prescription Program.

^b Alberta Works Health Benefit Program only.

^c Arranged by patient agreement.

^d Arranged by patient agreement.

^e Newfoundland and Labrador Prescription Drug Program can restrict patients to a maximum of two pharmacies.

^f Corrected on October 20, 2014. Enrolment in the NIHB PMP may restrict clients to a sole physician but does not restrict clients to a single-pharmacy (see page 28 for details).

Monitoring and Surveillance

Programs

Most provinces in Canada have established one or more mechanisms to control and/or monitor the use of prescription medications that may be abused. Programs take the form of mandatory electronic prescriptions, real-time monitoring systems that operate on data input at the point of sale, systems that use retrospective data captured over a period of time, and triplicate prescription pads. There is variation across the country as to the type of established systems and programs, how the systems operate, which medications are tracked, and how follow-up is conducted.

British Columbia

British Columbia has a Controlled Prescription Program (CPP) and three prescription-monitoring programs in place.

The CPP operates between the College of Physicians and Surgeons (CPSBC), the College of Pharmacists, the College of Dental Surgeons, the British Columbia Veterinary Medical Association, and the Ministry of Health Services PharmaCare Program.² The program mainly monitors narcotics, and CPP prescriptions for controlled drugs must be written on special CPP duplicate prescription pads. Prescriptions are numbered and individualized to the prescriber.²

Additionally, British Columbia PharmaCare monitors the use of benzodiazepines and stimulants for the treatment of attention-deficit hyperactivity disorder (ADHD). Gabapentin is not included on BC's list of monitored drugs.

The province's prescription-monitoring programs include:

- 1. PharmaNet** – All prescriptions dispensed in the province are entered into PharmaNet, the province-wide network that links all BC pharmacies to a central set of data systems. PharmaNet users include community pharmacies, hospital pharmacies,

emergency departments, medical practices, the College of Pharmacists of BC, and the CPSBC. PharmaNet is designed to prevent duplication of prescriptions and prescription fraud, protect patients from drug interactions and dosage errors, and promote cost-effective drug use. It offers authorized health professionals comprehensive medication information and provides immediate adjudication of claims under BC's PharmaCare Program. Pharmacists must check the patient's PharmaNet drug profile before dispensing any drug, including benzodiazepines and narcotics.

- 2. Prescription Review Program (PRP)** – The CPSBC PRP is a practice quality assurance program that performs periodic reviews of monitored drugs with the potential for abuse, misuse, or diversion. The program identifies problem prescribers and monitors their response to the PRP's interventions using the PharmaNet database, correspondence, interviews, Prescription Review Committee oversight, and educational sessions.
- 3. Opioid Trends Report** – Based on PharmaCare data, the Opioid Trends Report monitors trends in opioid use.

(Patrick Crawford, BC Ministry of Health, New Westminster, BC: personal communication, 2014 Feb 5; Ashifa Keshavji, BC Pharmacists, Vancouver, BC: personal communication, 2014 Jan 28; Dr. Ailve McNestry, College of Physicians and Surgeons of British Columbia, Vancouver, BC, personal communication, 2014 Jan 31).

Alberta

In Alberta, the prescription drug monitoring program is the Triplicate Prescription Program (TPP). Yukon Territory participates in Alberta's TPP.

The program objectives are to:

- Improve patient care by providing timely and relevant information on targeted drugs to prescribers, pharmacists and consumers.
- Reduce the misuse and abuse (non-medical use) of targeted medications.

- Monitor the prescribing and dispensing practices of physicians and pharmacists for the targeted medications.
- Provide timely, accurate information and feedback to prescribers and pharmacists regarding prescribing and dispensing practices and patterns for the targeted drugs.
- Identify potential areas of drug misuse or abuse and work with TPP partners to address issues.

The TPP is administered by the College of Physicians and Surgeons of Alberta (CPSA) on behalf of a multidisciplinary group that includes: Alberta Health, Alberta College of Pharmacists, Alberta Pharmacists Association, Alberta Medical Association, Alberta Dental College and Association, Alberta Veterinary Medical Association, Alberta Health Services, the College and Association of Registered Nurses of Alberta (CARNA) and the Yukon Medical Council.

Starting in 2014-2015 the TPP considers type 1 and type 2 medications, where type 1 requires the use of a secure three-part prescription form that is preprinted with the prescribers name and address. The triplicate prescriptions are numbered sequentially and if a prescription pad is lost or stolen, the prescriber is asked to report it. The CPSA website posts a list of type 1 medications.³ Ketamine and methylphenidate are monitored in addition to narcotics. Triplicate prescriptions are valid for 72 hours from the date prescribed. Type 2 medications are to be added to the program; these will not require the use of a triplicate prescription, but will require patient identifying information such as date of birth and Personal Health Number to ensure the information is captured accurately in the TPP database.⁴ Type 2 medications will include codeine-containing products, tramadol, benzodiazepines, and benzodiazepine-like drugs.

In 2013, the TPP began to rely on data from the Pharmaceutical Information Network (PIN).⁴ Consideration is now being given to modifying

the requirements to prescribe buprenorphine as well enhancing the monitoring requirements for stimulant medications.

Through the CPSA, prescribers and pharmacists can request TPP drug lists for a specific patient they are treating. Prescribers can also request their own TPP profile of what they have prescribed. Through the use of TPP data analyses, the CPSA identified a number of initiatives to reduce prescription drug abuse and associated harms:

- **High-Risk Patient Identification Project** — TPP data identified potentially high-risk patients who met all three of the following criteria:
 - on oral morphine equivalents of more than 600 mg daily
 - seeing more than two physicians
 - attending more than two pharmacies in a three-month period of time.

The feedback from this collaborative project with the Alberta College of Pharmacists and CPSA was provided to the physicians and pharmacists providing care to these patients. A notification letter with prescribing tools was provided to the health care providers involved by their respective regulatory body.

- **High Daily Oral Morphine Project** — Patients in the province on the highest daily oral morphine equivalent doses have been identified based on third quarter 2013 TPP data. An initiative is being developed with chronic pain physicians to provide monitoring support to the prescribing physicians for these patients.
- **Stimulants/buprenorphine** — With the availability of new safety data, Alberta reviewed and revised the monitoring practices of stimulant medications, and modified the prescription requirements of buprenorphine. In future, short-acting stimulant medications will require a secure

prescription, while longer-acting and tamper-proof stimulants will not.

- **Coalition on Prescription Drug Misuse⁵** — This coalition is comprised of organizations and individuals working collaboratively to reduce the harms associated with prescription drug abuse in Alberta. Participants include members of law enforcement, pharmacists, addiction treatment providers, and government representatives. The coalition contributed to the development of the CCSA’s national prescription drug abuse strategy “*First Do No Harm.*”¹

In addition to those monitoring programs identified by CPSA, Alberta Works prescription drug benefits are monitored by Alberta Blue Cross (ABC). Clients who meet established criteria indicating potential prescription drug misuse are identified on a monthly High Drug Utilization Report and may be restricted to visiting a single pharmacy on a monthly basis.⁶

As part of the Alberta Netcare Electronic Health Record (EHR), the PIN gives health care providers access to the list of patient’s active and previous medication(s).⁷ PIN is the central repository of the patients’ medication profile and includes a list of prescriptions, dispensing history, and known allergies and intolerances. Information is currently supplied by community and outpatient pharmacies; however, eventually PIN will include information from all other prescribers as well. The system allows pharmacies, physician offices, primary care sites, and other health facilities to exchange real-time information and can be used before prescribing or dispensing medication.

“Duplicate drug” messaging also occurs through adjudication processes.

(Karen Smilski, Government of Alberta, Edmonton, AB: personal communication, 2014 Jun; Dr. Janet L. Wright, College of Physicians and Surgeons of Alberta, Edmonton, AB: personal communication, 2014 Jan 3; Dale Cooney,

Alberta College of Pharmacists, Edmonton, AB: personal communication, 2014 Jan 15).

Saskatchewan

Administered by the College of Physicians and Surgeons, Saskatchewan’s PRP monitors the prescribing, dispensing, and use of substances listed on the program’s panel of monitored drugs. The PRP aims to “reduce the abuse and diversion ... based on current abuse and abuse potential in Saskatchewan.”⁸ Program partners include the Saskatchewan College of Pharmacists, the College of Dental Surgeons of Saskatchewan, the Saskatchewan Registered Nurses Association, and the Saskatchewan Ministry of Health.

The program is education-oriented, taking a “bottom-up” approach to identifying inappropriate prescribing and dispensing practices. Activities include the review of patient drug profiles, collaborating with the chief coroner to review methadone-related deaths, and working with law enforcement on illicit use and diversion issues.

The PRP alerts prescribers to possible issues of abuse and/or misuse, and provides guidance and recommendations to health professionals on appropriate prescribing and dispensing of monitored drugs.

Opioid prescribing has increased by only 4% in milligrams of morphine equivalents during the last two years, which indicates that the education-based PRP program has been effective in identifying apparent inappropriate prescribing and use of opioids.

Drugs subject to the province’s PRP include, but are not limited to:

- select narcotic and controlled drugs, such as methadone and hydromorphone
- amphetamines
- anabolic steroids
- barbiturates
- benzodiazepines
- buprenorphine

- chloral hydrate
- codeine-containing products
- diethylpropion
- gabapentin.

Increasing reports from law enforcement agencies on the sale and seizure of gabapentin prompted the addition of this substance to the list of monitored drugs. The province also identified safety concerns around meperidine and pentazocine, which resulted in the delisting of these two medications from the provincial formulary.

In addition to the PRP, Saskatchewan uses a Pharmaceutical Information Program (PIP) to prevent inappropriate prescribing and reduce substance abuse/misuse. The system helps prescribers select optimal medications to avoid adverse drug interactions, duplications of therapy, and potential drug abuse. If there is a documented history of prescription misuse, PIP patient profiles are reviewed by pharmacists to identify patients with a possible history of prescription misuse. It also facilitates the management of multiple medications in more complex treatment plans, and allows pharmacists to view prescriptions from multiple prescribers.

As part of Saskatchewan's PIP, the Medication Profile Viewer (MPV) stores prescription information electronically for each program beneficiary. Pharmacists must access the MPV system before dispensing. Information captured by the MPV on prescriptions includes date dispensed, drug quantity, name of dispenser, and pharmacy. Therefore, pharmacists can easily identify double-doctoring or multiple pharmacy use before filling or refusing a patient's prescription.

Additionally, the Pharmacy Online Claims processing system alerts pharmacists when a possible duplicate prescription is being dispensed within a certain time frame. The alert uses specific codes to indicate a duplicate prescription.

Pharmacists may only fill prescriptions for medications monitored by the PRP that are written, or electronically generated, with all of the legally required information:

- the patient's date of birth
- the patient's address
- the total quantity of medication prescribed, both numerically and in written form
- the patient's health services number
- the prescriber's name and address.

Because information is captured electronically, use of multiple prescription pads is no longer necessary.

All drugs, including narcotics and controlled drugs, can be prescribed electronically through the PIP to prevent forgery or illicit prescriptions.

In light of reports regarding the misuse of bupropion sustained-release, the PRP is monitoring for misuse and/or harm of this substance, requiring its possible inclusion into the monitored drugs list.

(Rachel Cheruvallath, Ministry of Health, Regina, SK: personal communication, 2014 Jan 15; Doug Spitzig, Prescription Review Program, College of Physicians and Surgeons, Saskatoon, SK: personal communication, 2014 Jan 28).

Manitoba

In May 2012, changes to Manitoba's *Prescription Drugs Cost Assistance Act* were made to strengthen monitoring and improve prescribing practices for narcotics, controlled drugs, and other drugs selected for monitoring. The changes included:

- Establishing a new category of drugs, called monitored drugs, to increase the monitoring of the prescribing, dispensing, and use of specific drugs listed in the legislation.
- Allowing regulatory bodies, such as the College of Physicians and Surgeons of Manitoba (CPSM), to work with Manitoba Health (MH) to monitor prescribing practices.

MH has adopted a prescription-monitoring program, and established an external expert drug review panel:

- The prescription-monitoring program, Improving Medication Prescribing and Outcomes Via Medical Education (IMPRxOVE) Program, which includes benzodiazepine and opioid prescribing, is an audit and feedback-based program. IMPRxOVE conducts monthly reviews of pharmacy-level claims data against clinical algorithms to identify prescribing patterns, which may deviate from evidence-based, best practice guidelines, and provides targeted feedback to the prescriber. Data reviewed is derived from resources such as the Drug Programs Information Network (DPIN). The IMPRxOVE Program is intended to improve patient health outcomes, drug utilization, and prescribing.
- Bill 14, *The Prescription Drugs Cost Assistance Amendment Act* (Prescription Drug Monitoring and Miscellaneous Amendments) provided authority for MH to strike the Manitoba Monitored Drugs Review Committee (MMDRC) to review prescribing, dispensing, and utilization of narcotics, benzodiazepines, and other drugs selected for monitoring. The committee has instituted a process to address findings, including advising health care providers of current guidelines and practices relating to prescribing and suggesting possible referrals to regulatory bodies for review of practices of concern.

Prescriptions are entered into DPIN, a real-time adjudication system used to process PharmaCare claims. As claims are received in the DPIN system, two concurrent processing streams are initiated: fiscal adjudication, which indicates whether a claim has benefit coverage and for what dollar amount and clinical adjudication. Clinical adjudication, or drug utilization review (DUR), evaluates the current prescription against the patient's drug history, determines potential adverse effects, and alerts the pharmacist to other precautions or

fraudulent activity. When necessary, the system sends a real-time warning and claims rejection message to the pharmacist at the point of sale. The DPIN is an adjudication tool designed to enhance prescription-monitoring practices in Manitoba by providing an additional source of information.

All sales of reportable narcotics and controlled drugs are included under the Manitoba Prescribing Practices Program (M3P). These include, but are not limited to, stimulants, codeine-containing products, Suboxone, and ketamine.⁹ When use of a particular drug has been identified as problematic, recommendations are made to the joint committee overseeing the M3P for inclusion of that drug in the M3P program.

MH monitors specified drugs, or classes of specified drugs under any of the following Anatomical Therapeutic Chemical (ATC) codes: N01A (Anesthetics, General), N02 (Analgesics), N05C (Hypnotics and Sedatives), and N06B (Psychostimulants, Agents Used for ADHD and Nootropics).

The College of Pharmacists of Manitoba also participates in the Manitoba Canadian Community Epidemiology Network on Drug Use (CCENDU), a monitoring and surveillance project that fosters and promotes networking among agencies that have common interests in local, national, and international drug trends and patterns. The college has contributed information and data regarding the M3P, prescription drug forgeries, and the theft of drugs from pharmacies in Manitoba to the annual provincial CCENDU report. This information is then compiled by the CCSA and disseminated nationally.

(Susan Lessard-Friesen, College of Pharmacists of Manitoba, Winnipeg, MB: personal communication, 2014 Feb 4; Kathy McDonald, Manitoba Health, Winnipeg, MB: personal communication, 2014 Jan 7).

Ontario

The Ontario government passed the *Narcotics Safety and Awareness Act, 2010*, which enables the Ontario Ministry of Health and Long-Term Care to track prescribing and dispensing activities relating to prescription narcotics and other controlled substances in Ontario. The legislation requires prescribers to record the patient's health card number and the prescriber registration number on each prescription for a monitored drug.

In 2012, the province implemented the Narcotics Monitoring System (NMS), which collects dispensing data from pharmacies in relation to all prescription narcotics and other monitored drugs. The NMS serves as a central database to enable retrospective reviews of dispensing activities and has real-time DUR capabilities. When a dispensing record is submitted by a pharmacy to the NMS, the system will conduct DUR checks.

Ontario's NMS issues alerts to pharmacy staff in real-time, if double-doctoring or multiple pharmacy use is detected. Information regarding individual patients, or prescribing patterns is not provided to physicians.

The province is working with practising physicians and pharmacists, as well as representatives from the College of Physicians and Surgeons of Ontario (CPSO), the Ontario College of Pharmacists (OCP), and professional associations to define the circumstances under which information from the NMS should be shared with prescribers, pharmacists, and regulatory bodies.

Ontario monitors any controlled substance under the *Controlled Drugs and Substances Act*, and other opioid medications not listed under the Act, such as tramadol and tapentadol.¹⁰

(Dr. Rocco Gerace, College of Physicians and Surgeons of Ontario, Toronto, ON: personal communication, 2013 Dec 20; Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Mar 4).

New Brunswick

In New Brunswick, a new Prescription Monitoring Act has received Royal Assent and will be proclaimed following the finalization of the Drug Information System (DIS).¹¹

It is anticipated that the DIS/Prescription Monitoring Program (PMP) will commence in 2014, with pharmacies beginning to submit data by fall 2014. Once launched, the PMP will include monitored drugs listed under the *Controlled Drugs and Substances Act* and the *Benzodiazepine and Other Targeted Substances Regulations* in addition to narcotics. It will also include benzodiazepine-like agents such as zopiclone and other opioids such as tramadol.

Currently, the New Brunswick Prescription Drug Program (NBPDP) employs a DUR process for program beneficiaries. The objective is to control, reduce, or identify narcotic, controlled and benzodiazepine drug usage, which may be harmful. Current legislation and system limitations constrain the capture of drug utilization information to NBPDP clients.

(Heidi Liston, New Brunswick Pharmaceutical Services, Department of Health and Wellness, Fredericton, NB: personal communication, 2014 Jan 23).

Nova Scotia

Nova Scotia has a Prescription Monitoring Program (NSPMP) established under the province's *Prescription Monitoring Act*. "Its objectives are to promote:

- The appropriate use of monitored drugs
- The reduction of abuse or misuse of monitored drugs."¹²

Under the authority of the Act, Medavie Blue Cross was appointed the Administrator of the NSPMP. As part of the NSPMP, Medavie implemented an online system that collects data on all monitored drugs dispensed from Nova Scotia community pharmacies, regardless of payer. All Nova Scotia residents are monitored by the PMP; therefore, information

on beneficiaries of all Pharmacare programs is included.

Any substance included under the *Controlled Drugs and Substances Act* (Canada) and listed in the Schedules to the *Act* or any successor legislation is subject to the NSPMP, except:

- Testosterone, when dispensed as a compound for topical application for local effect.
- Drugs listed in Parts 1 and 2 of Schedule 1 to the *Benzodiazepines and Other Targeted Substances Regulations* made under the *Controlled Drugs and Substances Act* (Canada).

It is anticipated that the NSPMP program will begin to monitor benzodiazepines in 2014.

The NSPMP has launched several service initiatives to guide and support prescribers and dispensers on the appropriate use of monitored drugs, and to protect the general public against misuse and abuse. Those related to monitoring and surveillance include:

- Patient Profiles — Prescribers, pharmacists and law enforcement can access detailed information regarding a patient's use of monitored drugs.
- Patient/Prescriber Agreement Monitoring — in situations where a prescriber deems a patient agreement to be appropriate, the NSPMP will monitor a patient's profile to ensure adherence to their treatment plan.
- eAccess — this is a service which allows prescribers and pharmacists the ability to log on to a secure website and obtain patient profile information either during or outside of the NSPMP's business hours. This will provide prescribers and pharmacists with access to information they need, when they need it, to determine the best treatment for their patient, while promoting the appropriate use and the reduction of abuse and/or misuse of monitored drugs.

Routine DURs of Pharmacare programs identify beneficiaries who are high-volume prescription drug users, identify prescriptions exceeding internally established drug thresholds, and report on incidents of multiple prescribing. Cases related to monitored drugs are typically referred to the PMP. Most often, these have already been identified through the PMP's activities. DURs notify physicians when patients are receiving medication from multiple doctors.

(Judith Fisher, Nova Scotia Department of Health and Wellness, Halifax, NS: personal communication, 2014 Jan 3; Kevin Lynch, Nova Scotia Prescription Monitoring Program, Halifax, NS: personal communication, 2014 Jan 22).

Prince Edward Island

The Prince Edward Island (PEI) DIS is a real-time monitoring record system that captures information on all prescriptions dispensed to residents, including those prescriptions filled for narcotics, benzodiazepines, stimulants and gabapentin. All pharmacies are linked to the DIS, and are legally mandated to use the system. The PEI Pharmacy Board has also mandated a monthly narcotic reconciliation program for pharmacies to monitor in-house inventory records.

Because the DIS captures information on all drugs for all patients, PEI does not employ a TPP. Because all dispensed drugs are monitored in the provincial DIS, PEI does not place additional substances on the monitored drug list.

Physicians have access to the DIS; however, this is not a legal requirement and less than half of island doctors have elected to subscribe.

The largest provincially run drug programs for which dispensing information is captured include the Seniors Drug Cost Assistance Program, which accounts for over half of prescriptions filled, and the Financial Assistance Drug Program, which accounts for approximately 25% of prescriptions filled

Though there is awareness that gabapentin is a drug of abuse, it is not considered a controlled substance at this time.

(Neila Auld, Prince Edward Island Pharmacy Board, Charlottetown, PEI: personal communication, 2014 Feb 6; Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2013 Dec 13).

Newfoundland and Labrador

Newfoundland and Labrador has a Tamper Resistant Prescription Drug Pad Program to reduce prescription drug abuse and diversion. Participation in the program is mandatory for all physicians, dentists, nurse practitioners and veterinarians in the province. All narcotic prescriptions must be written on these pads in order for a pharmacist to dispense the medication. In addition to narcotics, prescribers must use tamper resistant pads for other controlled substances including stimulants, codeine-containing products, hydromorphone, ketamine, and methadone.¹³

Practitioners are encouraged to keep prescription pads under lock and key, and must immediately report loss or theft to the Newfoundland and Labrador pharmacy board.¹⁴ Use of a tamper resistant pad is not required for benzodiazepines.¹⁴

Northwest Territories

The Northwest Territories is developing their Electronic Medical Record (EMR) system, a digital charting and reporting tool, and a central repository for all patient information in the Northwest Territories. Prescriptions for all drugs for all patients in the territory are written through the EMR. Because the EMR captures and updates information on all prescriptions in real-time, health care providers can unofficially monitor a patient's activities through the system. Only 55% of the population is registered in the database, but the program is slowly expanding to include all residents.

Prescriptions for narcotics are frequently faxed directly to the pharmacy, rather than given to the patient.

(Dr. Ewan Affleck, Director of Family Medicine, Yellowknife Health and Social Services Authority, Yellowknife, NT: personal communication, 2014 Jan 30).

Non-Insured Health Benefits

The Non-Insured Health Benefits (NIHB) program sends warning messages, as appropriate, to pharmacies during the assessment of drug claims for payment. For example, one of the messages the system could send to pharmacists would be to indicate that a client recently received the same drug at another pharmacy. The pharmacist may then be requested to provide a code to override the warning message. In addition, more specifically to drugs of concern, warning messages will be sent to address situations of possible drug misuse such as:

- three or more active prescriptions for benzodiazepines
- three or more active prescriptions for opioids
- a prescription for methadone in association with other opioid-based drugs.

To improve communication with health professionals and to enhance client safety, the NIHB Program has developed the NIHB PMP, which focuses on the inappropriate use of opioids, benzodiazepines, stimulants, and gabapentin. A methodology identifies NIHB clients that are misusing these drugs of concern and places the clients under certain restrictions with a view to prevent double doctoring by requesting that the client find a sole prescriber for the four types of drugs. If clients or their health care providers cannot follow the PMP process to support the continuation of the drug therapy in question, the program reserves the right to refuse coverage. The first phase of the NIHB PMP was launched in Alberta in January 2007. In September 2011, it was expanded to all regions in Canada, with the exception of Quebec.

NIHB is also enhancing its surveillance of prescribers and pharmacies for opioids, benzodiazepines, stimulant drugs and gabapentin by assessing historical data on prescribing and dispensing practices, such as high daily doses of medications and number of patients who are being prescribed these drugs. Individual interventions are done to engage physicians and pharmacies with a view to reduce prescription drug abuse. Interventions may also include discussions with prescribers on patterns of drug use in specific clients.

(Harold Boudreau & Carol Langlois, Non-Insured Health Benefits Program, Health Canada, Ottawa, ON: personal communication, 2013 Dec 12).

Program Evaluation

Jurisdictions reported that there is no current mechanism or program in place to capture the effectiveness of the prescription monitoring and surveillance programs being led across the country.

Forged, Illegitimate and Lost Prescription Policies

Along with the use of tamper resistant or triplicate prescription pads, several provinces and one federal drug plan have established interjurisdictional communication methods to report lost, forged or illegitimate prescriptions. The systems vary per jurisdiction, and a single jurisdiction may use a range of strategies and technologies to ensure notification of the appropriate stakeholders.

British Columbia

The College of Pharmacists and the PRP have a telephone fan-out system to alert pharmacies of forgeries and stolen prescription pads. Fan-out communications rely on reports from the College of Pharmacists, or third parties such as individual physicians or law enforcement.

(Ashifa Keshavji, BC Pharmacists, Vancouver, BC: personal communication, 2014 Jan 28; Dr. Ailve McNestry, College

of Physicians and Surgeons of British Columbia, Vancouver, BC, personal communication, 2014 Jan 31).

Alberta

Prescribers are asked to report stolen or lost triplicate prescription pads or single prescriptions to the Alberta College of Pharmacists (ACP), and a subsequent notification is sent out to pharmacies and pharmacists. Although the patient is not identified, a description, which may include their sex and age, is released. ACP also maintains a list of lost or stolen TPPs on their website. In 2010, CPSA conducted a survey of forged or altered prescriptions.¹⁵ Forgery and/or alteration of triplicate prescriptions on the secure pads were noted to be infrequent while regular prescriptions were altered more frequently.

(Dr. Janet L. Wright, College of Physicians and Surgeons of Alberta, Edmonton, AB: personal communication, 2014 Jan 3; Dale Cooney, Alberta College of Pharmacists, Edmonton, AB: personal communication, 2014 Jan 15).

Saskatchewan

If a forged or illegitimate prescription is identified by a pharmacy or by law enforcement officials, the PRP program is notified and the individual's drug use is monitored for an indefinite period of time. The aim of indefinite monitoring is to alert future prescribers to the patient's history of substance abuse or misuse, to protect the individual and/or the public from potential, future harm.

Saskatchewan's Ministry of Health reimburses pharmacies for refusing to fill certain medications when misuse and/or abuse are suspected. The "Refusal to Dispense" fee remunerates pharmacies when a pharmacist determines that the prescription has been altered or falsified, or if multiple pharmacies or double doctoring is suspected.

(Rachel Cheruvallath, Ministry of Health, Regina, SK: personal communication, 2014 Jan 15; Doug Spitzig, Prescription Review Program, College of Physicians and Surgeons, Saskatoon, SK: personal communication, 2014 Jan 28).

Manitoba

The College of Pharmacists of Manitoba coordinates a forgery alert system in the province. When a forged prescription is identified by either the pharmacist or the prescriber, or if a prescriber has identified that M3P prescriptions have gone missing and are presumed stolen, the college details this information in a “forgery alert” that is distributed by fax and email to all pharmacy managers in the province. Pharmacy managers are required to maintain a system within their pharmacy to ensure that this information is communicated to all pharmacy staff. When a pharmacist identifies a forged prescription, they are required to report this forgery to MH, the college and their local law enforcement agency. An individual prescriber may contact law enforcement directly, or report the forgery to the CPSM, or the College of Pharmacists of Manitoba (CPM). Additionally, the MH Provincial Drug Program sends notifications to pharmacists regarding use of fraudulent Personal Health Identification Numbers.

(Susan Lessard-Friesen, College of Pharmacists of Manitoba, Winnipeg, MB: personal communication, 2014 Feb 4; Kathy McDonald, Manitoba Health, Winnipeg, MB: personal communication, 2014 Jan 7).

Ontario

Prescribers may report forged, illegitimate, or lost prescriptions to the Ministry of Health and Long-Term Care, Ontario Public Drug Programs. The ministry sends an email notification to all pharmacies to alert them to the forged prescriptions or lost prescription pads.

(Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Sep 24).

Quebec

When a patient visits multiple pharmacies and multiple physicians and habit-forming drug therapy overlaps are found Quebec’s system, known as «Programme Alerte»¹⁶ sends out a warning (by a designated Ordre des pharmaciens du Québec [OPQ] staff member)

to the pharmacist and neighbouring pharmacies about that patient.

(Michel Caron, Ordre des pharmaciens du Québec, Montréal, QC: personal communication, 2014 Feb 12).

New Brunswick

The PMP will allow pharmacists to register a ‘Refusal to Fill’ for prescriptions using the online system. This new program feature may assist in identifying forged and illegitimate prescriptions.

(Heidi Liston, New Brunswick Pharmaceutical Services, Department of Health and Wellness, Fredericton, NB: personal communication, 2014 Jan 23).

Nova Scotia

The NSPMP prescription pads allow for centralized voiding of prescriptions, and the capability to track individual prescribers through the program’s electronic system. The NSPMP’s system can also issue alerts regarding criminal or concerning activities, and is able to share information with law enforcement when necessary.

(Kevin Lynch, Nova Scotia Prescription Monitoring Program, Halifax, NS: personal communication, 2014 Jan 22).

Prince Edward Island

When a pharmacy or physician in PEI identifies a forged or illegitimate prescription, they are required to notify the PEI Pharmacy Board. Upon notification a fan-out email is immediately generated to alert all pharmacists and pharmacies of the issue, using the DIS system.

(Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2013 Dec 13).

Cross-jurisdictional Communication

Respondents indicated that there is no communication mechanism in place between jurisdictions to monitor prescription use of narcotics, benzodiazepines, stimulants or

gabapentin. It was noted that development of a cross-jurisdictional communication system would enable jurisdictions to monitor double doctoring across borders.

Drug Plan Limits

Provincial and federal public drug plans manage the overuse of narcotics and other drugs of potential abuse by limiting the number of doses that can be reimbursed within a specific time period and by limiting early refills.

Alberta

In addition to having clients restricted to a particular pharmacy, Alberta Works clients who have been identified on a monthly High Drug Utilization Report may have quantity limits placed on some of their prescriptions.

The Government of Alberta drug plans have policies that apply to eligible drug benefits, including those with the potential for abuse:

- Early refill edit policy — applies to all drug claims where the days' supply is 90 days or more. Subsequent claims will be accepted only if 70% of the previous drug quantity has been used.
- Maximum days' supply policy — the maximum quantity that can be dispensed at one time is 100 days (although limits of 31 or 34 days may apply for some plans and drugs).
- Claims will not be covered for multiple fills of the same drug (DIN) for the same patient on the same day.
- Assessment for refusal to fill a prescription — pharmacists may claim a fee for this service in cases of potential for overuse/abuse, or a falsified or altered prescription.

(Karen Smilski, Government of Alberta, Edmonton, AB: personal communication, 2014 June).

British Columbia

British Columbia's PharmaCare program has implemented five policies to manage overuse of narcotics and other drugs of abuse:

- Special Authorization — most sustained-release opioid products are only available for coverage through Special Authorization based on predefined clinical criteria.
- Maximum Days' Supply Policy — PharmaCare coverage of short-term medications, including opioids, benzodiazepines, and barbiturates, is a maximum 30-day supply.
- Early Refill Policy — PharmaCare does not cover prescription refills when there is more than a 14-day supply remaining from a previous fill. An exception is made when there is a legitimate reason to provide the beneficiary with an early fill.
- Same Day Policy — PharmaCare does not cover multiple fills of the same prescription for the same patient on the same day unless an appropriate intervention code is entered.
- Special Services Fee — Pharmacists are entitled to claim a PharmaCare fee for "special services" when they choose not to fill a prescription for if they suspect overuse, multiple pharmacy use, or double doctoring by a patient.

(Patrick Crawford, BC Ministry of Health, New Westminster, BC: personal communication, 2014 Feb 5).

Saskatchewan

Adjudication rules limit the number of prescriptions that can be filled to three submissions in a 45-day period. If prescriptions are dispensed more frequently, pharmacists must contact the drug plan and provide a reason for the increase before payment is authorized. The prescriber may also be requested to provide clinical background information, documentation, or a letter regarding the need for increased prescription frequency.

The drug plan will also allow for “daily witnessed ingestion” and weekly/biweekly fills of medications where abuse/misuse is of concern.

In Saskatchewan all narcotics except for fentanyl and some limited use/special authorization requests are adjudicated online. For fentanyl to be adjudicated electronically, a prescription for oral sustained-release or injectable opioids, such as hydromorphone, oxycodone, or morphine, must have been filled in the past six months.

(Rachel Cheruvallath, Ministry of Health, Regina, SK: personal communication, 2014 Jan 15).

Manitoba

MH has no specific reimbursement policies in place to manage overuse of narcotics, benzodiazepines, stimulants or gabapentin. However, utilization is managed, to a degree, through the formulary listing status of medications, such as those substances that are ineligible for benefits or that are listed as Exception Drug Status. For example:

- OxyNeo is listed as a benefit under Part 3 Exception Drug Status, and is available only to clients who meet defined criteria.
- Generic OxyContin is not an eligible benefit.

(Kathy McDonald, Manitoba Health, Winnipeg, MB: personal communication, 2014 Jan 7).

Ontario

In Ontario, some narcotics are reimbursed through the limited use mechanism or through the Exceptional Access Program, both of which require prescribers to document the patient’s eligibility criteria.

Effective February 29, 2012, OxyContin was removed as a Limited Use benefit from the Ontario Drug Benefit (ODB) Formulary and OxyNeo was funded through the Exceptional Access Program (EAP) for chronic pain and through the Facilitated Access for Palliative Care Drugs mechanism for the treatment of cancer-related pain, or pain in patients receiving end-

of-life palliative care. OxyNeo 60 mg and 80 mg tablets are not funded under the EAP. OxyNeo 80 mg tablets are funded under the Palliative Care Drugs mechanism. For all requests considered under the EAP, physicians are encouraged to follow best practice guidelines for the safe and effective use of opioids in chronic non-cancer pain, such as the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.¹⁷

(Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Sept 24).

Atlantic Provinces (collectively)

The introduction of OxyNeo and the issues associated with oxycodone prompted the Atlantic Common Drug Review, a collective body of the Atlantic Provinces, to investigate the interchangeability of long-acting and short-acting opioids. The Atlantic Provinces are also developing procedures that would restrict access to these and other narcotic substances.

(Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2014 Jan 3).

New Brunswick

In addition to the DUR process, the NBPDP applies annual quantity limits to narcotics, stimulants, benzodiazepines, and zopiclone. If a beneficiary reaches their quantity limit, the prescriber must call the Interactive Voice Response system to override the quantity limit, which then activates the reimbursement.

(Heidi Liston, New Brunswick Pharmaceutical Services, Department of Health and Wellness, Fredericton, NB: personal communication, 2014 Jan 23).

Prince Edward Island

Prince Edward Island has a total of 27 drug programs, 11 of which are accessible through retail pharmacies. Some of these plans restrict early refills entirely, while others require that at least 80% of the time duration has passed

between refills before the system will pay for the next claim.

The largest drug programs in the province include the PEI Seniors' Drug Cost Assistance Program, which accounts for nearly half of all Health PEI drug claims, and the Financial Assistance Drug Program, which makes up approximately 25% of these claims. The seniors program allows for medication refills after 80% time has passed, whereas the financial assistance plan does not allow for early release of any prescriptions.

Pharmacists are expected to use professional judgment and deny requests for early refills where abuse or misuse is suspected.

(Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2013 Dec 13).

Non-Insured Health Benefits

The NIHB Program has set quantity limits on a number of drugs through dose limit initiatives at the point of sale (pharmacy). These policies target overuse of drugs to increase client safety. New dose limits include:

- Opioids — Effective September 30, 2013, a daily opioid dose limit set at 600 mg has been implemented. A new dose limit at 500 mg morphine equivalents per day is taking effect October 20, 2014. Clients who have been identified, as palliative or cancer patients, are excluded from opioid dose limitations. The objective of this initiative is to monitor and gradually reduce the number of program clients receiving doses of opioids above the “watchful dose” of 200 mg morphine equivalents per day, as recommended in the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cance*.¹⁷ These dose limits are based on best practice, client safety, and are intended to trigger communication with providers and prescribers concerning high doses of opioids and to encourage

prescribers to safely taper clients to an appropriate dose.

- Gabapentin — dose limit lowered to 4,000 mg/day (as of February 2014).
- Benzodiazepines — dose limit lowered to 60 mg/day (as of September 2014). The limit will be lowered again in the future to a target dose of 40 mg/day.

Of note, as of October 2013, a dose limit of 3600 mg/day of acetaminophen has been placed on products containing acetaminophen as a single ingredient or in combination with an opioid.

In addition, all opioids listed are subject to a maximum 30-day supply when filling a prescription.

(Harold Boudreau & Carol Langlois, Non-Insured Health Benefits Program, Health Canada, Ottawa, ON: personal communication, 2013 Dec 12).

Methadone and Suboxone Prescribing Policies

Five provinces (BC, Alta., Man, Que., NS) and one federal drug program (NIHB) specifically highlighted one or more mechanisms to support the safe prescribing of methadone. Some examples include updating prescriber policies, tracking patient and prescriber data, and instituting educational initiatives for clinicians and pharmacy staff.

It was also identified that Suboxone is available as a Limited Use or Regular benefit on some of the provincial formularies.

British Columbia

British Columbia has a methadone maintenance treatment (MMT) program. The MMT program is delivered based on a maintenance-oriented as opposed to abstinence-oriented philosophy.

British Columbia's PharmaCare program collaborated with the College of Physicians and Surgeons of BC, the College of Pharmacists of

BC, and other organizations to transition from providing extemporaneously compounded methadone to commercially available Methadose 10 mg/mL, effective February 1, 2014. Methadose must only be dispensed as the commercially available 10 mg/mL methadone oral preparation. Additionally all pharmacists and staff, including relief staff must complete a mandatory College of Pharmacists of British Columbia MMT training program before dispensing the 10 mg/mL preparation. All pharmacists and pharmacy staff must self-record the completion of their training in the eServices database.

In response to the dosage change, the College of Pharmacists of British Columbia will soon release an updated version of their *Methadone Maintenance Handbook* which is accessible on the college's website.¹⁸ The college CPSBC also plans to revise their handbook *Recommendations for the Use of Methadone for Pain*,¹⁹ in the coming year.

The College of Pharmacists has updated *Professional Practice Policy 66 (PPP-66) Methadone Maintenance Treatment (MMT)*²⁰ and their Policy Guide to ensure that practices and service delivery are consistent among all provincial pharmacies.

A specific drug-related change involves Suboxone, which is now available as a limited benefit on the BC PharmaCare formulary. Suboxone was added in response to a retrospective BC government 12-year study (*Methadone Maintenance Treatment in British Columbia, 1996-2008, Analysis and Recommendations, May 2010*)²¹ that suggests many opioid-dependent patients are not able to access methadone treatment or are not benefiting from methadone.

(Patrick Crawford, BC Ministry of Health, New Westminster, BC: personal communication, 2014 Feb 5; Ashifa Keshavji, BC Pharmacists, Vancouver, BC: personal communication, 2014 Jan 28; Dr. Ailve McNestry, College of Physicians and Surgeons of British Columbia, Vancouver, BC, personal communication, 2014 Jan 31).

Alberta

CPSA administers the methadone exemption process under the CPSA Methadone Program to support physicians in providing treatment to patients who may benefit from treatment. The college has created Standards and Guidelines for Methadone Maintenance Treatment and also coordinates the delivery of an introductory workshop regarding MMT.²²

Prescribing requirements for methadone for the treatment of opioid dependence include:

- apply for a methadone exemption, which requires a letter of support from the college
- attend the MMT introductory workshop.

In 2013, the *Alberta Methadone Maintenance Treatment Standards and Guidelines for Dependence*²³ were updated to reflect current evidence and best practices to address safety concerns.

In collaboration with the Centre for Addiction and Mental Health, and the Faculty of Medicine at the University of Calgary, the CPSA is developing an online course for MMT for opioid addiction.

Increased experience with buprenorphine, improved safety and challenges with accessing MMT prompted the CPSA to review their prescribing requirements. After consultation with physicians with expertise in the treatment of opioid dependency, CPSA Council approved prescribing changes for buprenorphine/naloxone (Suboxone) to help remove barriers in patient care, particularly for patients in hospitals, other health care settings with controlled medication dispensing process (e.g., nursing homes), or for incarcerated patients.

Physicians will not be required to have a methadone exemption in order to prescribe buprenorphine in opioid-dependent patients. Specific education and experience will be required in specified clinical circumstances.²⁴

(More details are available on the CPSA website.)

Suboxone is a Regular Benefit of the Government of Alberta sponsored drug plans.

(Karen Smilski, Government of Alberta, Edmonton, AB: personal communication, 2014 Jun; Dr. Janet L. Wright, College of Physicians and Surgeons of Alberta, Edmonton, AB: personal communication, 2014 Jan 3; Dale Cooney, Alberta College of Pharmacists, Edmonton, AB: personal communication, 2014 Jan 15).

Manitoba

The Manitoba Pharmaceutical Association has developed a guideline document, *Principles for the Provision of Methadone by Manitoba Pharmacists*. Pharmacists must also comply with contractual agreements made regarding the dispensing of these drugs with Drug Programs at MH and the First Nations and Inuit Health Branch of Health Canada.

A continuing professional development (CPD) program for health care providers, *Methadone: An Introduction to Clinical Practice* has been developed by the CPD Division of the Faculty of Medicine at the University of Manitoba, in partnership with the CPM.

(Susan Lessard-Friesen, College of Pharmacists of Manitoba, Winnipeg, MB: personal communication, 2014 Feb 4; Kathy McDonald, Manitoba Health, Winnipeg, MB: personal communication, 2014 Jan 7; Dr. Anna Ziomek, College of Physicians and Surgeons of Manitoba, Winnipeg, MB: personal communication, 2014 Jan 17).

Ontario

The OCP maintains the MMT and Dispensing Policy, and the CPSO maintains the Methadone Maintenance Treatment for Opioid Dependence policy as well as the MMT Program Standards and Clinical Guidelines. These policies are enforced by the colleges to ensure safe prescribing and dispensing of methadone according to current standards and evidence.

Suboxone is currently funded under the ODB Program as a Limited Use benefit.

(Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Sept 24).

Quebec

The Collège des médecins du Québec manages an official list of physicians authorized to prescribe methadone. All methadone prescriptions dispensed by these practitioners are monitored by the Collège des médecins du Québec in collaboration with L'Ordre des pharmaciens du Québec.

(Michel Caron, Ordre des pharmaciens du Québec, Montréal, QC: personal communication, 2014 Feb 12; Dr. Ernest Prigent, M.D. Collège des médecins du Québec, Montréal, QC: personal communication, 2014 Jan 28).

Nova Scotia

The NSPMP includes a Methadone Program Monitoring component, which assists methadone clinics in ensuring that patients access no other monitored drugs during their treatment.²⁵

Non-Insured Health Benefits

When a client is on methadone, it is important that all other opioids, benzodiazepines, stimulants drugs, and gabapentin are closely monitored by physicians and pharmacists to maximize safety and effectiveness and minimize the risk of harm, abuse, and diversion and to ensure that prescribers of these drugs are aware that a client is on methadone. Therefore, NIHB has made MMT a Limited Use benefit. Clients approved for methadone are placed in the PMP, which ensures that only one prescriber writes prescriptions for each of the above-mentioned classes of drugs.

This methadone policy was implemented for NIHB clients in New Brunswick in August 2011, in all other Atlantic Provinces in March 2012, Saskatchewan in May, 2013, in Manitoba in September 2013, Alberta in March 2014, and Ontario in September 2014. The expansion of the restriction to the four classes of drugs is currently being planned in all provinces. The methadone policy will be expanded to clients in all provinces based on program capabilities.

Suboxone is currently listed on the NIHB Drug Benefit List (DBL) as a Limited Use benefit. PMP restrictions concerning benzodiazepines, stimulants, and gabapentin also apply to Suboxone. A justification from the prescriber for each opioid prescription is requested by the NIHB Program for a client on Suboxone.

(Harold Boudreau & Carol Langlois, Non-Insured Health Benefits Program, Health Canada, Ottawa, ON: personal communication, 2013 Dec 12).

Other Initiatives

Education

Beyond policy development, a range of initiatives to address prescription drug abuse and misuse are being undertaken independently and collaboratively by the governments and regulatory colleges across Canada. This includes ongoing support for the *First Do No Harm: Responding to Canada's Prescription Drug Crisis* strategy, developed by the CCSA and promotion of the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*.^{1,17}

Clinicians across Canada have access to a variety of in-person and online educational opportunities focused on prescription drug abuse. Education is offered by a variety of providers including the regulatory colleges, university-affiliated continuing medical education programs, and governments through programs such as academic detailing.

In 2014, the National Pain Centre at McMaster University, which hosts the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, launched a new online teaching module entitled "Opioids for Chronic Non-Cancer Pain: Using the Canadian Guideline in Your Practice." This is a free, accredited training program for physicians.²⁶

Canadian pharmacists have access to an independent study program entitled "Prescription Opioid Misuse: What Pharmacists Really Need to Know" through the Canadian Council on Continuing Education in Pharmacy (CCCEP).²⁷

The range and nature of initiatives varies across the country. As guidance for the dispensing and use of drugs of abuse change in Canada, jurisdictions have developed support tools for prescribers in the form of published guidelines. Some are working collaboratively with law enforcement and community groups.

British Columbia

In 2014, the BC Ministry of Health's academic detailing program will offer a new unit entitled *Opioids in Chronic Non-Cancer Pain: The Basics*²⁸ to educate physicians and health professionals on the safe and appropriate use of opioids.

The CPSBC organizes an annual series of educational courses. In 2014 to 2015 the following courses related specifically to narcotics and other drugs of potential abuse will be offered:

- A Prescribers Course: To assist physicians in developing communication strategies for counselling patients with chronic pain.
- A Methadone 101/Hospitalist workshop.
- Opioids for Chronic Non-Cancer Pain: Using the Canadian guideline in your practice.

The complete list of events is available on the college's website.²⁹

(Patrick Crawford, BC Ministry of Health, New Westminster, BC: personal communication, 2014 Feb 5; Ashifa Keshavji, BC Pharmacists, Vancouver, BC: personal

communication, 2014 Jan 28; Dr. Ailve McNestry, College of Physicians and Surgeons of British Columbia, Vancouver, BC, personal communication, 2014 Jan 31).

Alberta

The CPSA has been tracking the changes in use of certain opioids during the past 10 years and has noted an increase in the use of oxycodone preparations. This information is being used to direct educational activities and prescribing support for its members including the following:

- **Opioid Treatment Course** —CPSA is developing an Alberta-specific online version of the Centre for Addiction and Mental Health's Opioid Dependence Treatment course. As well, they are creating a secure online portal where physicians can obtain their individual prescribing profile that they can compare to a peer group.
- **Drug Use in the Elderly** — The CPSA and the Alberta Medical Association are developing an electronic prescribing practice support tool, "Optimized Prescribing in Seniors," for Alberta physicians. The resource will provide evidence-based practical advice about medication management for seniors. Benzodiazepine and opioid prescribing have been identified as important topics to address in this support tool.
- **Guideline Update** — The ACP is collaborating with the CPSA to update the ACP "Medication-Assisted Treatment for Opioid Dependence Guidelines."
- **Training Program** — CPSA and ACP development of an Alberta-specific training program based on the Centre for Addiction and Mental Health (CAMH) Methadone Treatment Program.
- **Nurse Practitioner Controlled Drug Substances (CDS) Prescribing Requirements.**³⁰ — As of 2014, nurse practitioners in Alberta can prescribe controlled substances. They are required to complete a CDS educational module recognized by CARNA and a CARNA CDS jurisprudence exam to be authorized to prescribe controlled drugs and substances. All graduates after September 2015 will be

eligible to automatically prescribe, as the content will be incorporated into all Alberta training programs.³¹

(Dr. Janet L. Wright, College of Physicians and Surgeons of Alberta, Edmonton, AB: personal communication, 2014 Jan 3; Karen Smilski, Government of Alberta, Edmonton, AB: personal communication, 2014 Jun).

Saskatchewan

Educational initiatives for physicians and nurse practitioners in Saskatchewan include seminars on narcotic and monitored drug topics. Materials covered include national guidelines such as the *Canadian Guideline for Safe and Effective Use of Opioids for Non-Cancer Pain*¹⁷ and the Canadian ADHD Resource Alliance (CADDRA) Guidelines.³² Clinicians are also referred to appropriate manuals and best practice for appropriate prescribing of other PRP medications such as benzodiazepines.

The Saskatchewan College of Pharmacists recommends participation in its national online seminars, as well as workshops offered through organizations such as CADTH, the National Pain Centre, and the Canadian Society of Addiction.

The province also assists in developing local programs for drug strategy committees; performs educational outreach through college newsletters; and offers presentations for physicians immigrating to the province with intent to practice.

Saskatchewan's ongoing involvement in the *National Drug Strategy First Do No Harm: Responding to Canada's Prescription Drug Crisis*¹ includes not only monitoring and surveillance activities but also education and awareness initiatives, treatment recommendations, and lobbying for appropriate legislative changes.

(Doug Spitzig, Prescription Review Program, College of Physicians and Surgeons, Saskatoon, SK: personal communication, 2014 Jan 28).

Manitoba

The CPM participates on committees in conjunction with MH, the Addictions Foundation of Manitoba and, therefore indirectly, the CCSA, to develop new policies, practices or initiatives related to the prescribing and dispensing of narcotic and controlled drugs.

In support of MH's initiative to tackle the issue of oxycodone abuse, the CPM has participated on a long-standing multi-stakeholder committee including other health-related organizations, the Addictions Foundation of Manitoba, law enforcement, and social service agencies. During the last several years, this committee has been involved in developing recommendations for government on education and awareness programs for the public and health providers, and the provincial legislation to help address the issue of oxycodone abuse.

Since 2003, the CPM has participated on the Board of Partners Seeking Solutions with Seniors (PSSS). PSSS comprises a network of more than 60 stakeholders who have come together to promote awareness and increase knowledge concerning issues of substance misuse and abuse among older adults, and to facilitate access to and the adoption of a range of evidence-based prevention and treatment options. Stakeholders in PSSS include seniors, senior-serving organizations, health care organizations and individual practitioners, addiction service providers, self-help groups, government, and academia.³³

In Manitoba, the CPSM is exploring options with the provincial government to develop a prescribing audit program. If an audit program is launched, educational initiatives will be included.

In addition, recommendations by the MMDRC have led to the revision of teaching materials used for medical students and residents at the University of Manitoba. Materials have been updated to emphasize issues around the management of chronic pain, including the

related appropriate use of narcotics and benzodiazepines.

Education for practising physicians about the use of narcotics and benzodiazepines is also offered by the University of Manitoba's CPD group.

(Susan Lessard-Friesen, College of Pharmacists of Manitoba, Winnipeg, MB: personal communication, 2014 Feb 4; Kathy McDonald, Manitoba Health, Winnipeg, MB: personal communication, 2014 Jan 7; Dr. Anna Ziomek, College of Physicians and Surgeons of Manitoba, Winnipeg, MB: personal communication, 2014 Jan 17).

Ontario

Although the CPSO does not provide education on prescribing, information about prescribing issues is published on a periodic basis in the college magazine *Dialogue*. For example, a 2012 article entitled "*The Emergency Room: Not the right place for chronic pain management*"³⁴ recommended the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*¹⁷ as a primary resource for Ontario physicians, and included additional recommendations for enabling effective opioid policies in the emergency room.

The CPSO promotes the University of Toronto's Safe Opioid Prescribing Course for physicians seeking further education.

(Dr. Rocco Gerace, College of Physicians and Surgeons of Ontario, Toronto, ON: personal communication, 2013 Dec 20; Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Mar 4).

Quebec

Institutions in the province such as universities, the Fédération des médecins omnipraticiens du Québec, and the Fédération des médecins spécialistes du Québec provide courses on narcotics, benzodiazepines, stimulants and other drugs of abuse, often as CPD activities.³⁵

The Collège des médecins provides both web and paper-based publications on chronic pain

management, sedation and analgesia, and other topics of concern. The college also periodically offers a workshop on chronic pain management.

The Institut national d'excellence en santé et en services sociaux is publishing references, guidelines, and warnings on some drugs such as oxycodone.

In 2008, the Ordre des pharmaciens du Québec conducted a continuing education session in various cities on the topic of the management of acute and chronic pain. Modules covered the proper use of narcotics and other substances, including gabapentin.

(Michel Caron, Ordre des pharmaciens du Québec, Montréal, QC: personal communication, 2014 Feb 12; Dr. Ernest Prigent, M.D. Collège des médecins du Québec, Montréal, QC: personal communication, 2014 Jan 28).

New Brunswick

New Brunswick intends to offer an educational initiative to accompany the new Atlantic Common Drug Review policy on quantity limits for narcotic drugs once the policy is in place.

(Heidi Liston, New Brunswick Pharmaceutical Services, Department of Health and Wellness, Fredericton, NB: personal communication, 2014 Jan 23).

Nova Scotia

The NSPMP provides information on monitored drugs to the public, practitioners, and researchers through the following initiatives:

- **Prescriber Peer Comparison Reports** —This report is available to prescribers upon request. It provides a graphical representation of their individual prescribing pattern in relation to their peers in their District Health Authority, and in the province overall.
- **Data Sharing for Research** —The NSPMP acts as a resource for researchers by providing statistical information and aggregate data on monitored drug use.

- **Medical Consultant** – The NSPMP consultant is an independent physician with expertise in prescribing opioids and is available as a resource to health care professionals, NSPMP staff, and NSPMP committees.²⁵

Additionally, by 2017 the NSPMP expects to support:

- 24-hour access to the information needed by prescribers and dispensers
- continued transfer of prescription data from the Nova Scotia DIS to the NSPMP database
- elimination of the duplicate prescription pad system
- drug utilization research
- linkage with educational providers delivering interventions related to the prescribing and use of monitored drugs
- collaboration among jurisdictions to achieve the objects of the program.

(Judith Fisher, Nova Scotia Department of Health and Wellness, Halifax, NS: personal communication, 2014 Jan 3; Kevin Lynch, Nova Scotia Prescription Monitoring Program, Halifax, NS: personal communication, 2014 Jan 22).

Prince Edward Island

The Association of Registered Nurses and the Medical Society of Prince Edward Island hosted a one-day conference in October 2013 entitled “Addictions Unplugged: Dispelling myths and facing facts, moving forward in addictions training in PEI.” Among the sessions were:

- Myths & Facts Surrounding Opioid Replacement Therapy on PEI.
- Update on Methadone Prescribing.
- Narcotics and Safety Awareness Act — What you need to know.³⁶

(Neila Auld, Prince Edward Island Pharmacy Board, Charlottetown, PEI: personal communication, 2014 Feb 6; Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2013 Dec 13).

Northwest Territories

In 2012, the Northwest Territories released their *Controlled Substances: Territorial Prescription Guide*. “The purpose of the guidelines is to standardize the proper use of controlled substances by assisting the clinician”³⁷ with identifying at-risk or addicted patients, drug choice, dosing and dispensing practices, and other prescribing principles. The guide includes “Tools to Minimize Risk of Misuse and Abuse,” and contains, among other information, recommendations around developing treatment agreements with patients and scheduling pill-counting appointments.³⁷ At this time, the Northwest Territories is unable to monitor for adherence to these guidelines.

(Dr. Ewan Affleck, Director of Family Medicine, Yellowknife Health and Social Services Authority, Yellowknife, NT: personal communication, 2014 Jan 30).

Prescriber Profiles

Several jurisdictions have mechanisms in place to identify high-volume prescribers. To address this issue follow-up activities include notification of the prescriber, and education and training to influence behaviour change.

British Columbia

The CPSBC’s PRP is a practice quality assurance program that identifies problem prescribers and monitors their response to the PRP’s interventions using the PharmaNet database, correspondence, interviews, Prescription Review Committee oversight, and educational sessions.

(Patrick Crawford, BC Ministry of Health, New Westminster, BC: personal communication, 2014 Feb 5).

Alberta

The CPSA identified the following initiatives to provide feedback on individual physician prescribing practices for opioids and benzodiazepines:

- **First Nations and Inuit Health Branch Project** —In 2010, at the request of four

First Nations community leaders, the CPSA contacted clinicians with the highest rates of benzodiazepine and opioid prescribing in First Nations communities. Prescribing data, educational resources and practice tools, along with periodic feedback were provided to the physicians identified. Follow-up indicated that the majority of the identified physicians had reduced their benzodiazepine and opioid prescribing.

- **Meperidine Project** – Initiated in 2011, this intervention focused on physicians prescribing more than 600 mg of meperidine daily for more than three months. The physicians were given feedback, educational resources, and prescribing tools. Some were asked to provide clinical information to support their prescribing. By 2013, the majority of the physicians had reduced or ceased prescribing meperidine to the index patient.

In addition, consideration is being given to the development of an online secure portal, which will allow physicians to obtain their own prescribing profile in comparison to a similar peer group.

(Dr. Janet L. Wright, College of Physicians and Surgeons of Alberta, Edmonton, AB: personal communication, 2014 Jan 3).

Saskatchewan

Saskatchewan’s PIP is a secure, web-based computer application that provides pharmacists, physicians, nurses, dentists, optometrists, and other authorized health care providers, with confidential access to accurate medication histories of Saskatchewan patients.

The PIP captures prescriber profiles, which enables the identification of inappropriate prescribing. In cases of inappropriate prescribing, an educational intervention is initiated for the physician. This same process applies to a practitioner if a patient in their care is identified as misusing and/or abusing a substance.

The PRP sends out alert letters to warn prescribers of potential double-doctoring cases.

(Doug Spitzig, Prescription Review Program, College of Physicians and Surgeons, Saskatoon, SK: personal communication, 2014 Jan 28; Rachel Cheruvallath, Ministry of Health, Regina, SK: personal communication, 2014 Jun 9).

Manitoba

MH's Opiate Monitoring Intervention Program, a subcomponent of the Manitoba IMPRxOVE Program with an additional focus on narcotics and other monitored drugs, will be launched in early 2014. The Opiate Monitoring Intervention Program will include the introduction of opiate-specific mailings to prescribers and new analytical capacity reports to specifically monitor the appropriateness of opioid prescribing. Areas of review will include multiple prescribers, high-dose use, and patients receiving combinations of products such as opioids and benzodiazepines, which place patients at risk.

(Kathy McDonald, Manitoba Health, Winnipeg, MB: personal communication, 2014 Jan 7).

Ontario

In 2012, the province implemented the NMS, which collects dispensing data from pharmacies in relation to all prescription narcotics and other monitored drugs. The NMS serves as a central database to enable retrospective reviews of dispensing activities and has real-time DUR capabilities. When a dispensing record is submitted by a pharmacy to the NMS, the system will conduct DUR checks.

Ontario's NMS issues alerts to pharmacy staff in real-time, if double-doctoring or multiple pharmacy use is detected. Information regarding individual patients, or prescribing patterns is not provided to physicians.

The province is working with practising physicians and pharmacists, as well as representatives from the CPSO, the OCP, and professional associations to define the circumstances under which information from

the NMS should be shared with prescribers, pharmacists, and regulatory bodies.

(Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Sept 24).

New Brunswick

New Brunswick's DUR process is performed on a retrospective basis (i.e., after beneficiaries receive their prescriptions). A report is generated once a month that identifies beneficiaries who have met one or both of the following criteria: used two or more physicians or used two or more pharmacies. In cases where further investigation is warranted, a six-month profile is obtained and reviewed on an individual basis. The physician(s) and pharmacies related to each individual case will be contacted if a patient's profile includes one or more of the following criteria:

- multiple physicians/pharmacies
- duplication of therapy
- excess daily dosage
- long-term/escalating use
- multiple narcotic, controlled, and/or benzodiazepine drugs/high-prescription volumes, dollars, and/or quantities
- external alerts/requests (pharmacy alerts, individual physician or pharmacy requests).

In the event of harmful activity, contact is initiated with health care professionals to provide information regarding the patient's drug usage about which they may be unaware. A quarterly aggregate report listing prescribers who received the greatest number of letters may be provided to the New Brunswick College of Physicians and Surgeons upon request

(Heidi Liston, New Brunswick Pharmaceutical Services, Department of Health and Wellness, Fredericton, NB: personal communication, 2014 Jan 23).

Nova Scotia

In 2014, the NSPMP will provide individual prescribing profiles and supportive information, such as information on continuing medical

education and provincially monitored drug data, to the province's 100 highest volume prescribers. An information package for prescribers being piloted in 2014 is designed to be non-punitive and supportive of a prescriber's practice. Individual profiles will compare a practitioner's prescribing habits with peers in their District Health Authority and the province overall.

As well, through the NSPMP, all clinicians in Nova Scotia have access to their Prescriber Peer Comparison Reports, which provides a graphical representation of their individual prescribing pattern in relation to their peers.

(Judith Fisher, Nova Scotia Department of Health and Wellness, Halifax, NS: personal communication, 2014 Jan 3; Kevin Lynch, Nova Scotia Prescription Monitoring Program, Halifax, NS: personal communication, 2014 Jan 22).

Prince Edward Island

Prince Edward Island is developing a system that will run reports on a regular basis to extract data on all prescriptions filled for drugs regulated under the *Controlled Drugs and Substances Act* (Canada). These reports will be generated to identify high-volume prescribers, dispensers, and users. When harmful behaviours are identified, information captured by these reports will enable Health PEI to educate prescribers, dispensers, or users; or, upon failure to educate, report cases to regulatory bodies; or, if necessary, report cases to criminal authorities. The province is currently establishing a committee to advise on the level and type of action needed when a case of misuse and/or abuse is identified.

This initiative follows from the province's new Narcotics Safety and Awareness Act,³⁸ which also grants ministerial authority to engage in direct contact with health-related regulatory bodies and the criminal justice system.

(Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2013 Dec 13).

Newfoundland and Labrador

The Newfoundland and Labrador Prescription Drug Program works in collaboration with their Medical Claims office to review narcotic prescribing behaviour among physicians in relation to their peers. This same initiative reviews patient claims and utilization.

(Patricia Clark, Department of Health and Community Service, Newfoundland and Labrador, St. John's, NL: personal communication, 2014 Jan 9).

Prescriber and Pharmacy Designations

Jurisdictions reported systems to identify instances of double-doctoring or high-volume users, and the strategies, such as patient contracts and single-pharmacy designation, to address these issues.

British Columbia

British Columbia runs a Restricted Claimant Program to reduce problematic medication use. The program limits coverage for patients with identified histories of misuse and/or abuse to medications prescribed by a single practitioner, or dispensed by a single pharmacy. Physicians and pharmacists must communicate this information to the patient.

The program only applies to prescriptions paid for by PharmaCare, and patients may avoid adherence by paying for their own drugs. However, a new dispensing pharmacist would be able to view the patient's information through the PharmaNet system. The new pharmacist could then ask the patient about their reasons for infringing upon the restriction, and engage the beneficiary in a dialogue that would hopefully encourage compliance.

Pharmacists are not mandated to alert the new physician with whom the patient is double doctoring. But, if the pharmacist chooses to do so, the new doctor could then limit the prescribing of the drug in question or cancel the prescription.

(Patrick Crawford, BC Ministry of Health, New Westminster, BC: personal communication, 2014 Feb 5; Ashifa Keshavji, BC Pharmacists, Vancouver, BC: personal communication, 2014 Jan 28; Dr. Ailve McNestry, College of Physicians and Surgeons of British Columbia, Vancouver, BC, personal communication, 2014 Jan 31).

Alberta

Only the Alberta Works Health Benefits Program, which covers low income and unemployed citizens, has a restriction policy in place. If a client is identified as a high-volume user, their case worker can restrict prescription drug coverage to one pharmacy by having restrictions applied to their Health Benefits Card.

Prescribers working with other beneficiaries are encouraged to develop agreements with the patient, and sometimes the pharmacy, whereby the patient assents to limit their treatment to one doctor and one pharmacy. Because information regarding dispensing is available to both physicians and pharmacists on Netcare, non-adherence can be checked through the system.

(Dale Cooney, Alberta College of Pharmacists, Edmonton, AB: personal communication, 2014 Jan 15; Karen Smilski, Government of Alberta, Edmonton, AB: personal communication, 2014 Jun).

Manitoba

MH is able to use its DPIN to restrict a patient to filling prescriptions at a particular pharmacy. This restriction is initiated at the request of the physician and with the agreement of the patient. Where MH is the sole payer for the cost of the prescribed medication for a patient, MH has the authority to limit reimbursement to only one pharmacy, with or without the consent of the patient. The pharmacy filling the prescriptions must contact the drug program to “open” the patient’s file before they can begin dispensing for that individual.

In addition, MH has a Patient Utilization Review Committee (PURC), which is mandated to monitor those registrants who are receiving

medical care and/or prescription drugs that are not medically necessary, and who may be inappropriately using the health care system. Upon the recommendation of the individual’s physician, PURC may ask the registrant to voluntarily sign an agreement to restrict their access to one physician and one pharmacy in the interest of better medical care. This restriction agreement does not apply to emergency room visits or access to medical specialists.

(Susan Lessard-Friesen, College of Pharmacists of Manitoba, Winnipeg, MB: personal communication, 2014 Feb 4).

Ontario

The Health Network System (HNS) links all Ontario pharmacies to the ministry for online claims processing and adjudication in real-time. The HNS provides pharmacists with a DUR program that reviews previous prescription information/claims data and current prescription data to identify potential problems. The prospective DUR monitors for potential double doctoring, duplicate prescriptions, potential multiple pharmacy use, in addition to drug interactions. The pharmacy receives the DUR messages in real-time and can review the information with the patient or prescriber as necessary before dispensing.

(Angie Wong, Drug Program Services Branch, Ontario Ministry of Health and Long-Term Care, Toronto, ON: personal communication, 2014 Sept 24).

Quebec

In Quebec, restrictions on physician prescribing of narcotics can be brought into effect as a result of a disciplinary decision or a voluntary engagement by the physician after a review of his practice or a pre-disciplinary agreement. The list of physicians authorized to dispense narcotics is maintained and monitored by the college and transmitted to the Régie de l'assurance maladie du Québec.

(Dr. Ernest Prigent, M.D. Collège des médecins du Québec, Montréal, QC: personal communication, 2014 Jan 28).

In 1985, «Programme Alerte», was created by the Ordre des pharmaciens du Québec to encourage the appropriate use of drugs. The program¹⁶:

- Assists pharmacists in identifying patients who are misusing substances that are known to be habit-forming (mainly benzodiazepines and opioids), following a request by a pharmacist. Misuse is identified when a patient visits multiple pharmacies and multiple physicians, and habit-forming drug therapy overlaps are found.
- When a patient has been identified, a warning is sent by a designated OPQ staff member to the pharmacist and neighbouring pharmacies about that patient.
- When said patient visits a pharmacy, he/she is invited to select one physician and one pharmacy for his/her drug therapy needs (for the drugs that the patient has been misusing and/or abusing).

(Michel Caron, Ordre des pharmaciens du Québec, Montréal, QC: personal communication, 2014 Feb 12).

Nova Scotia

The decision to designate a single pharmacy to dispense a patient's medications is determined by physicians in consultation with his/her patient. The NSPMP may offer this as a suggestion to a physician as a strategy to limit misuse, abuse or diversion. The NSPMP then monitors patient agreements and reports on a weekly basis any patient who receives controlled drugs from a pharmacy or physician outside of their appointed care team.

All pharmacists are required to register with the NSPMP. All monitored drugs dispensed are to be reported by pharmacists to the NSPMP at the time of dispensing if there is an issue with the submission such as a system-based error. This allows the NSPMP to provide real-time data to prescribers and pharmacists. The program completes audits of pharmacies to confirm submission and data integrity.

The program also issues alerts to pharmacies regarding double doctoring or stolen prescription pads. Before dispensing, pharmacists also receive electronic notifications on the patient's file, which indicates multiple pharmacy use, or double doctoring.

(Kevin Lynch, Nova Scotia Prescription Monitoring Program, Halifax, NS: personal communication, 2014 Jan 22).

New Brunswick

Under the NBPDP's DUR process, limitations to the access of narcotics, controlled drugs, and benzodiazepines are occasionally placed upon some beneficiaries. When this is necessary, the beneficiary will be restricted to access one physician and one pharmacy in the province. The decision to enact restrictions against a patient is based on reviews and recommendations received from prescribers.

Once the province's Prescription Monitoring Program is fully rolled out, prescribers will be able to register a patient monitoring agreement with the PMP system. Registration establishes that the patient has agreed to be limited to one prescriber and one pharmacy. If the individual attempts to fill a prescription from a different prescriber or use a different pharmacy, the system will generate an alert to warn the patient's care team.

(Heidi Liston, New Brunswick Pharmaceutical Services, Department of Health and Wellness, Fredericton, NB: personal communication, 2014 Jan 23).

Prince Edward Island

In Prince Edward Island, pharmacists, physicians and patients may enter into a unified agreement that limits the patient's use to a single pharmacy. An email confirming the agreement is then sent out to all pharmacies through the DIS.

Since dispensing of all drugs in the province is recorded by the DIS, a patient using multiple pharmacies will be identified by the system,

including any patient infringing upon their agreement. A real-time warning about a patient's multiple pharmacy use can then be communicated by email to all PEI pharmacists.

The province's government drug programs can designate a substance as a Special Authorization drug, even if the drug is open benefit. This restricts dispensation of the medication to a single pharmacy, and/or a single prescriber.

(Neila Auld, Prince Edward Island Pharmacy Board, Charlottetown, PEI: personal communication, 2014 Feb 6; Roy Cairns, Department of Social Services and Seniors Provincial Drug Plans, Charlottetown, PEI: personal communication, 2013 Dec 13).

Newfoundland and Labrador

In Newfoundland and Labrador, a patient's access to all prescriptions can be restricted to a maximum of two pharmacies. However, this policy can only be enacted against public drug plan beneficiaries. In cases where a restriction is necessary, the patient and his/her associated health care providers are advised of the issue and processes involved.

(Patricia Clark, Department of Health and Community Service, Newfoundland and Labrador, St. John's, NL: personal communication, 2014 Jan 9).

Northwest Territories

Practitioners in the Northwest Territories frequently develop contracts with patients whereby the patient agrees to utilize a particular pharmacy. Information about the patient's pharmacy is then recorded in the EMR database, which can be accessed by all pharmacists and physicians. However, the territory does not officially monitor for adherence to these contracts. Although only 55% of the population in the Northwest Territories is entered in the EMR system, once the program is fully rolled out, all records for all Northwest Territories residents will be accessible through the system.

(Dr. Ewan Affleck, Director of Family Medicine, Yellowknife Health and Social Services Authority, Yellowknife, NT: personal communication, 2014 Jan 30).

Non-Insured Health Benefits

Enrolment in the NIHB PMP may restrict clients to a sole physician. Clients placed on the PMP are requested to find a sole prescriber for their prescriptions of opioids, benzodiazepines, stimulants, and gabapentin. The PMP does not restrict clients to a single pharmacy.

(Harold Boudreau & Carol Langlois, Non-Insured Health Benefits Program, Health Canada, Ottawa, ON: personal communication, 2013 Dec 12).

Conclusions

The survey of Canada's publicly funded drug plans, colleges of physicians and surgeons, and colleges of pharmacists shows that jurisdictions have established multiple avenues to address the issue of prescription drug abuse.

Formal monitoring and surveillance programs, such as PMPs and prescriber information programs, exist in the majority of jurisdictions. These systems allow for the identification of high prescribers and high users of drugs of potential abuse. Many of the jurisdictions also identify and educate clinicians about potentially harmful prescribing habits. In some jurisdictions, collaboration between the drug plans and the colleges has led to the creation of systems that link pharmacies to patient and prescriber data. Other jurisdictions have implemented similar systems to reduce patients' abilities to access drugs through multiple pharmacies or by double doctoring. Incentive programs for pharmacies have also been reported for "refusal to fill" prescriptions where there is suspicion of polypharmacy, double doctoring, or a falsified prescription. Some publicly funded drug plans have placed limits on narcotics, benzodiazepines, stimulants, and gabapentin or offer them only through Special Authorization. Professional regulatory colleges have also led initiatives including the development of the *Canadian Guideline for Safe*

and Effective Use of Opioids for Chronic Non-Cancer Pain¹⁷ as well as through the provision of free, online, accredited, professional development modules.

Given the variety of policies, practices, and initiatives observed across the country, potential opportunities to enhance efforts to address prescription drug abuse in Canada include:

- Establishing province-wide monitoring and surveillance systems that track prescriptions for all citizens, not just for clients of publicly funded drug programs.
- Addressing interjurisdictional communication through mechanisms such as EMR systems.
 - Continuing ongoing support for the “First Do No Harm” strategy¹ being led by the CCSA.
 - Continuing to support initiatives to promote awareness and use of the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*.¹⁷
- Establishing methods to identify and educate high-prescribers in jurisdictions that currently lack such a system.
- Establishing dose and quantity limits for narcotics, benzodiazepines, stimulants, and gabapentin in jurisdictions that currently do not set limits, based on the best available evidence.
- Increasing community collaboration to support appropriate prescribing among special populations such as seniors, and to support law enforcement initiatives.
- Evaluating the effectiveness and impact of existing international initiatives and best practices.

References

1. National Advisory Committee on Prescription Drug Misuse. First do no harm: responding to Canada's prescription drug crisis [Internet]. Ottawa (ON): Canadian Centre on Substance Abuse; 2013. [cited 2014 Feb 25]. Available from: <http://www.ccsa.ca/Resource%20Library/Canada-Strategy-Prescription-Drug-Misuse-Report-en.pdf>
2. Controlled prescription program [Internet]. Vancouver (BC): College of Pharmacists of British Columbia; 2011 Mar. [cited 2014 May 5]. Available from: http://library.bcpharmacists.org/D-Legislation_Standards/D-4_Drug_Distribution/5015-ControlledPrescriptionProgram.pdf
3. College of Physicians & Surgeons of Alberta. Triplicate prescription program (TPP): medication list [Internet]. Edmonton (AB): CPSA; 2012. [cited 2014 Jul 14]. Available from: http://www.cpsa.ab.ca/Libraries/pro_tpp/TPP_MedicationList_Generic.pdf?sfvrsn=0.
4. College of Physicians & Surgeons of Alberta [Internet]. Edmonton (AB): College of Physicians & Surgeons of Alberta. The Messenger: Prescribing corner: Codeine prescribing in Alberta; 2013 Jan 9 [cited 2014 May 5]. Available from: http://www.cpsa.ab.ca/resources/the-messenger/prescribingcorner/13-01-09/Codeine_Prescribing_in_Alberta.aspx
5. Coalition on Prescription Drug Misuse (CoOPDM) [Internet]. Edmonton (AB): CoOPDM. About CoOPDM; 2010 [cited 2014 Jul 14]. Available from: <http://www.prescriptiondrugmisuse.ca/about-coopdm/>
6. Health benefits card coverage [Internet]. Edmonton (AB): Government of Alberta. 07 High volume drug use; 2011 [cited 2014 Jul 14]. Available from: <http://humanservices.alberta.ca/AWonline/HB/4707.html>

7. Welcome to Alberta Netcare Learning Centre [Internet]. Edmonton (AB): Government of Alberta. Pharmaceutical Information Network (PIN); 2014 [cited 2014 Jul 14]. Available from: <http://www.albertanetcare.ca/LearningCentre/PIN.htm>
8. Richard G, Ojala V, Ojala A, Bowles SK, Banh HL. Monitoring programs for drugs with potential for abuse or misuse in Canada. *Can Pharm J (Ott)* [Internet]. 2012 Jul [cited 2014 Mar 17];145(4):168-71. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3567799>
9. Manitoba Prescribing Practices Program. List of drugs covered by the Manitoba prescribing practices program (M3P) [Internet]. Winnipeg: College of Pharmacists of Manitoba; 2013. [cited 2014 Feb 25]. Available from: <http://mpha.in1touch.org/uploaded/38/web/Revised%20M3P%20list%20Feb%202013.pdf>
10. Your health services [Internet]. Toronto: Ontario Ministry of Health and Long-Term Care. List of monitored drugs; 2013 [cited 2014 Sep 30]. Available from: http://health.gov.on.ca/en/pro/programs/drugs/ons/monitored_drugs.aspx
11. Prescription monitoring act = Loi sur la surveillance pharmaceutique [Internet]. In: New Brunswick Acts and Regulations. Fredericton (NB): Queen's Printer for New Brunswick; 2009. Chapter P-15.05 [cited 2014 Feb 25]. Available from: <http://laws.gnb.ca/en/ShowPdf/cs/P-15.05.pdf>.
12. Prescription Monitoring Program strategic plan 2013 to 2016 [Internet]. Halifax (NS): Nova Scotia Prescription Monitoring Program; 2012. [cited 2014 Feb 25]. Available from: <http://www.nspmp.ca/library/00000292-library.pdf>
13. Schedule 1 - Drugs required to be written on tamper resistant pads [Internet]. St. John's (NL): Department of Health and Community Services. Government of Newfoundland and Labrador; 2011 Sep 1. [cited 2014 Feb 25]. Available from: http://www.health.gov.nl.ca/health/prescription/schedule_of_drugs_tamper_resistent.pdf
14. Department of Health and Community Services [Internet]. St. John's (NL): Department of Health and Community Services. Government of Newfoundland and Labrador. Tamper resistant prescription drug pad program; 2014 [cited 2014 Feb 25]. Available from: http://www.health.gov.nl.ca/health/prescription/hcp_tamperresistantdrugpad.html
15. College of Physicians & Surgeons of Alberta. Programs and services: physician prescribing practices program (P4) [Internet]. Edmonton (AB): CPSA. Prescribing fraud survey results - 2010; 2010 [cited 2014 Jul 14]. Available from: http://www.cpsa.ab.ca/services/Physician_PREScribing_Practices/PrescribingFraudSurvey.aspx
16. Le programme alerte [Internet]. Montreal (QC): Ordre des pharmaciens du Quebec; 2008. [cited 2014 Feb 25]. Available from: http://www.opq.org/cms/Media/255_38_fr-CA_0_depliant_programme_alerte.pdf
17. National Opioid Use Guideline Group (NOUGG). Canadian guideline for safe and effective use of opioids for chronic non-cancer pain [Internet]. 5.6. Hamilton (ON): National Opioid Use Guideline Group (NOUGG); 2010 Apr 30. [cited 2014 Apr 23]. Available from: <http://nationalpaincentre.mcmaster.ca/opioid/>
18. Methadone maintenance handbook [Internet]. Vancouver (BC): College of Physicians and Surgeons of British Columbia; 2009. [cited 2014 Feb 25]. Available from: <https://www.cpsbc.ca/files/pdf/Methadone-Maintenance-Handbook-PUBLIC.pdf>
19. College of Physicians and Surgeons of British Columbia. Recommendations for the use of methadone for pain [Internet]. Vancouver: The College of Physicians and Surgeons of British Columbia; 2010 Feb. [cited 2014 Apr 25]. Available from: <https://www.cpsbc.ca/files/pdf/Methadone-Program-Recommendations-for-the-Use-of-Methadone-for-Pain-PUBLIC.pdf>

20. Methadone maintenance treatment [policy on the Internet]. Vancouver (BC): College of Pharmacists of British Columbia; 2010. (Professional practice policy- 66). [cited 2014 Feb 25]. Available from: http://library.bcpharmacists.org/A-About_Us/A-2_Governance/5003-PGP-PPP66.pdf
21. Methadone maintenance treatment in British Columbia, 1996-2008: analysis and recommendations [Internet]. Victoria (BC): University of Victoria Centre for Addictions Research BC; 2010 May. [cited 2014 Feb 25]. Available from: http://www.health.gov.bc.ca/library/publications/year/2010/Methadone_maintenance_treatment_review.pdf
22. College of Physicians & Surgeons of Alberta [Internet]. Edmonton (AB): CPSA. Methadone program; 2014 [cited 2014 Jul 14]. Available from: http://www.cpsa.ab.ca/services/methadone_program/Methadone_Program_Overview.aspx
23. Alberta methadone maintenance treatment standards and guidelines for dependence [Internet]. Edmonton (AB): College of Physicians & Surgeons of Alberta; 2014. [cited 2014 Sep 30]. Available from: http://www.cpsa.ab.ca/Libraries/pro_methadone/alberta-mmt-standards-guidelines.pdf?sfvrsn=4
24. College of Physicians & Surgeons of Alberta serving the public by guiding the medical profession [Internet]. Edmonton (AB): College of Physicians & Surgeons of Alberta. Physician prescribing practices program (P4). Prescribing buprenorphine (Suboxone®) for opioid dependence; 2013 [cited 2014 Sep 30]. Available from: http://www.cpsa.ab.ca/Services/Physician_Prescribing_Practices/BuprenorphinePrescribing.aspx
25. Welcome to the Nova Scotia Prescription Monitoring Program [Internet]. Halifax (NS): Nova Scotia Prescription Monitoring Program. About us; 2013 [cited 2014 Feb 25]. Available from: <http://www.nspmp.ca/about.php>
26. MDCme.ca [course details on the Internet]. St. John's (NF): Professional Development and Conferencing Services. Course information opioids for chronic non-cancer pain: using the Canadian guideline in your practice; 2014 [cited 2014 Apr 23]. Available from: <https://www.mdcme.ca/courseinfo.asp?id=127>
27. Canadian Council on Continuing Education in Pharmacy = Conseil canadien de l'éducation permanente en pharmacie [Internet]. Saskatoon (SK): Canadian Council on Continuing Education in Pharmacy (CCCEP). 2014 [cited 2014 Apr 25]. Available from: <http://www.cccep.org/> CCCEP tools require membership.
28. Ministry of Health [course details on the Internet]. Victoria: BC Ministry of Health. Opioids in chronic non-cancer pain (CNCP): the basics; 2014 [cited 2014 Apr 25]. Available from: <http://www.medmatters.bc.ca/info-hprof/pad-opioids.html>
29. College of Physicians and Surgeons of British Columbia [Internet]. Vancouver (BC): College of Physicians and Surgeons of British Columbia. SME events: mark your calendars; 2014 [cited 2014 Apr 23]. Available from: <https://www.cpsbc.ca/for-physicians/college-connector/2013-V01-02/05>
30. NP prescribing controlled drugs & substances [Internet]. Edmonton (AB): College & Association of Registered Nurses of Alberta; 2014. [cited 2014 Sep 9]. Available from: <http://www.nurses.ab.ca/content/carna/home/professional-resources/practice-resources/nurse-practitioner-resources/np-prescribing-controlled-drugs-substances.html>
31. Nurse practitioners beginning to prescribe controlled drugs and substances [Internet]. Edmonton (AB): College & Association of Registered Nurses of Alberta; 2014. [cited 2014 Sep 9]. Available from: <http://www.nurses.ab.ca/content/carna/home/current-issues-and-events/announcements/NP-CDS.html>

32. Canadian ADHD Resource Alliance (CADDRA). Canadian ADHA practice guidelines (CAP-Guidelines) [Internet]. 3rd. Toronto: Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA); 2011. [cited 2014 Apr 25]. Available from: <http://www.caddra.ca/pdfs/caddraGuidelines2011.pdf>
33. Seniors Resource Network of Manitoba [Internet]. Winnipeg (MB): Seniors Resource Network. Welcome to partners seeking solutions with seniors; 2014 [cited 2014 Sep 30]. Available from: <http://solutionsforseniors.cimnet.ca/cim/29.dhtm>
34. Blake J. The emergency room: not the right place for chronic pain management. Dialogue [Internet]. 2012 [cited 2014 Feb 25];(3):31-2. Available from: http://www.cpso.on.ca/cpso/media/uploadedfiles/members/resources/practicepartner/chronic-pain-management_dial-issue3-2012.pdf
35. Continuing Education and Professional Development. Safe opioid prescribing [course details on the Internet]. Toronto: University of Toronto Faculty of Medicine. 2014 [cited 2014 Feb 25]. Available from: <http://www.cepd.utoronto.ca/opioidprescribing/>
36. Association of Registered Nurses of Prince Edward Island, Medical Society of Prince Edward Island. Addictions unplugged: dispelling myths & facing facts moving forward in addictions training in PEI [conference program on the Internet]. Cornwall (PE): Association of Registered Nurses of Prince Edward Island; 2013. [cited 2014 Feb 25]. Available from: <http://www.arnpei.ca/images/documents/Brochure%20final.pdf>
37. Controlled substances: Territorial prescription guidelines [Unpublished internal report]. Yellowknife (NT): Government of the Northwest Territories; 2012.
38. Legislative Counsel Office. Narcotics safety and awareness act [Internet]. Charlottetown (PEI): Legislative Counsel Office; 2013 Sep 14. Cap. N-.01. [cited 2014 May 5]. Available from: http://www.gov.pe.ca/law/statutes/pdf/n-0_01.pdf

APPENDIX 1: ABBREVIATIONS LIST

AB	Alberta
ACP	Alberta College of Pharmacists
ADHD	attention-deficit/hyperactivity disorder
BC	British Columbia
CADDRA	Canadian ADHD Resource Alliance
CADTH	Canadian Agency for Drugs and Technologies in Health
CCENDU	Canadian Community Epidemiology Network on Drug Use
CCSA	Canadian Centre on Substance Abuse
CPD	continuing professional development
CPM	College of Pharmacists of Manitoba
CPP	Controlled Prescription Program
CPSA	College of Physicians and Surgeons of Alberta
CPSBC	College of Physicians and Surgeons of British Columbia
CPSM	College of Physicians and Surgeons of Manitoba
CPSO	College of Physicians and Surgeons of Ontario
DIS	drug Information System
DUR	drug Utilization Review
DPIN	Drug Plan Information Network
EAP	Exceptional Access Program
EMR	Electronic Medical Record
IMPRxOVE	Improving Medication Prescribing and Outcomes Via Medical Education
M3P	Manitoba Prescribing Practices Program
MB	Manitoba
MH	Manitoba Health
MMDRC	Manitoba Monitored Drugs Review Committee
MMT	Methadone Maintenance Treatment
MPV	Medication Profile Viewer
NB	New Brunswick
NBPDP	New Brunswick Prescription Drug Program
NIHB	Non-Insured Health Benefits
NL	Newfoundland and Labrador
NMS	Narcotics Monitoring System
NS	Nova Scotia
NSPMP	Nova Scotia Prescription Monitoring Program
ON	Ontario
OPQ	Ordre des pharmaciens du Québec
PEI	Prince Edward Island
PIP	Pharmaceutical Information Program
PMP	Prescription Monitoring Program
PRP	Prescription Review Program
PSSS	Partners Seeking Solutions with Seniors
PURC	Patient Utilization Review Committee
QC	Quebec
SK	Saskatchewan
TPP	Triplicate Prescription Program

Cite as: Smith N, Quansah K, Chelak K, Fitzsimmons H. Narcotics, benzodiazepines, stimulants, and gabapentin: policies, initiatives, and practices across Canada, 2014. Ottawa: Canadian Agency for Drugs and Technologies in Health; 2014. (Environmental Scan; issue 45).

CADTH takes sole responsibility for the final form and content of this environmental scan. The statements and conclusions in this environmental scan are those of CADTH.

Production of this report is made possible by financial contributions from Health Canada and the governments of Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, Prince Edward Island, Saskatchewan, and Yukon. The Canadian Agency for Drugs and Technologies in Health takes sole responsibility for the final form and content of this report. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

Disclaimer: The Environmental Scanning Service is an information service for those involved in planning and providing health care in Canada. Environmental Scanning Service responses are based on a limited literature search and are not comprehensive, systematic reviews. The intent is to provide information on a topic that CADTH could identify using all reasonable efforts within the time allowed. Environmental Scanning Service responses should be considered along with other types of information and health care considerations. The information included in this response is not intended to replace professional medical advice nor should it be construed as a recommendation for or against the use of a particular health technology. Readers are also cautioned that a lack of good quality evidence does not necessarily mean a lack of effectiveness, particularly in the case of new and emerging health technologies for which little information can be found but that may in future prove to be effective. While CADTH has taken care in the preparation of the report to ensure that its contents are accurate, complete, and up to date, CADTH does not make any guarantee to that effect. CADTH is not liable for any loss or damages resulting from use of the information in the report. **Copyright:** This report contains CADTH copyright material. It may be copied and used for non-commercial purposes, provided that attribution is given to CADTH. **Links:** This report may contain links to other information available on the websites of third parties on the Internet.

Canadian Agency for Drugs and Technologies in Health (CADTH)
600-865 Carling Avenue,
Ottawa, Ontario K1S 5S8