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B.C.'s pharmacy information source

ReadLinks

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The other side of the counter

Pharmacist with chronic pain takes her peers to task

Diane Campbell is a B.C. pharmacist who wants to share her experiences as a chronic-pain patient while offering suggestions on how to best serve this small, sometimes misunderstood, group.

Diane Campbell

I am a pharmacist who practised in a community setting for a decade until I was forced to stop working by a back injury. As a result, I have had the opportunity to see pharmacy staff from the other side of the counter, as a chronic-pain patient. It's been a revelation. I wish that everyone could have the chance to bring in an opioid prescription to the pharmacy they work in and find out what it's like being on the receiving end of pharmacy service.

After much thought, I have come up with a few tips that I hope to put into practice as soon as I am able to return to work.

1. **Be familiar with pain management guidelines.**

When I was on methadone last year, I was shocked at the hostility I encountered at some pharmacies. The staff seemed unaware that methadone is used to treat chronic pain and they regarded me with suspicion. Remember, people with chronic pain may be taking methadone or high doses of other narcotics long term.

2. **Treat opioid prescriptions as legitimate, until you have grounds for suspecting otherwise.**

You can reconcile proper vigilance for drug diversion with compassion for patients. If you treat a patient with hostility, chances are they'll become flustered, even if their prescription is legitimate. As a side effect of pain medication, they may be sweating profusely and dry-mouthed. These may be warning signs for someone up to no good, but they may also point to someone who is suffering and who needs to be treated, at the very least, with courtesy.

3. **Know the difference between physical dependence and addiction.**

Addiction is an obsession with obtaining a substance despite an individual's knowledge that the drug they crave causes physical, social, and/or financial damage. Physical dependence is when the body becomes accustomed to a substance and experiences withdrawal reactions when the substance is abruptly removed.

I am physically dependent on OxyContin®. If I forget one of my regular doses, I will start feeling ill after a few hours. I hate feeling shackled to my dosette, and I despair at the side effects and the stigma of taking a widely abused drug. Unfortunately, I am stuck with the choice of taking a medication I find repugnant or suffering crippling pain.

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In this issue

Three to get ready

Marshall Moleschi, Marnie Mitchell (BCPhA), and Robert Sindelar (UBC) gathered earlier this spring to map out a first: an inaugural trip by the leaders of this province's three pharmacy bodies to visit with pharmacists in Fort St. John and Dawson Creek. They were also joined by pharmacists from Tumbler Ridge and Fort Nelson.

COLLEGE of PHARMACISTS OF BRITISH COLUMBIA

www.bcpharmacists.org

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ReadLinks

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Your questions and comments about this newsletter are welcome and may be forwarded to the registrar.

The *ReadLinks* newsletter provides important college and pharmacy practice information. All pharmacists are expected to be aware of these matters.

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from the Registrar

If you want truly to understand something, try to change it.

Kurt Lewin, organizational theorist

Marshall Moleschi

Change takes time

How can we work together toward the vision of fully engaging pharmacists in patient-centred care? Pharmacists are the drug experts, with the skills and training to provide safe, effective, and accessible care. There is agreement that all pharmacists should be engaged in patient-oriented care. Some pharmacists are doing this now, and others continue to join them. The question is, how can the CPBC help create an environment where every pharmacist is engaged?

Our profession has many facets and issues, for instance:

- In some ways, we are a fragmented profession. We practise in hospitals and community pharmacies, with the latter ranging from supermarkets to small independents.
- The majority of pharmacists work in the private sector, with a variety of business types, from self-owned to publicly traded corporations.
- Competition and efficiency are a reality in community pharmacy, and now these concepts are knocking at the door of hospital pharmacy practice.

We have seen many attempts to improve the profession over the past few years. Community and hospital pharmacies have strived to remake themselves into better organizations. These efforts have taken place under many banners: total quality management, re-engineering, right sizing, restructuring, culture change, and turnarounds. A few of these efforts have been very successful, and a few have been utter failures; most fall somewhere in between. One important thing to keep in mind is the pace involved when embarking on something new. Change involves numerous phases that, together, usually take a long time. Rushing creates only an illusion of speed and never produces a satisfying result.

Organizational expert John P. Kotter, in his article "Leading change: Why transformation efforts fail," lists seven steps for effective change: establishing a sense of urgency for change; creating a vision; communicating the vision; removing obstacles to the new vision; systematically planning for and creating short-term wins; not declaring victory too soon; and making change part of the culture. Skipping any of these steps will slow or stop the change process. Kotter's points are as appropriate for pharmacies as they are for other businesses or organizations, including the CPBC.

On that note, college council, staff, and other pharmacy stakeholders recently discussed a series of strategic goals, including more patient-focused care opportunities, to make sure the college continues to meet its mandate of protecting the public and supporting pharmacists in a changing world. However, while external events move at a pace beyond our control, we need to remember that the road to ensuring our profession's relevance and importance, within a myriad of practice and organizational models, will be best traveled with reasoned, well thought-out directions.

A big thank you to the 210 people who took part in the strategic goals survey! Your feedback will be invaluable as we move toward bringing the strategic goals to life.

COLLEGE MISSION: To ensure British Columbia pharmacists provide safe and effective pharmacy care to help people achieve better health.

Pharmacist suspended

David Rands, diploma 2606, defrauded PharmaCare

In February 2005, pharmacist David Rands pleaded guilty in provincial court to charges of fraud over $5,000 contrary to Section 380(1) (a) of the Criminal Code. Mr. Rands was sentenced to imprisonment for two years less a day, and was released after four months due to good behaviour. On February 22, 2006 a College of Pharmacists of B.C. discipline panel held a hearing to determine the consequences of Mr. Rands' conviction.

The discipline panel reviewed a summary of the charges and relevant information presented by the college lawyer and Mr. Rands' lawyer. Mr. Rands defrauded the Ministry of Health's PharmaCare program of $471,001 over a seven-month period between November 1999 and June 2000. He knowingly used an incorrect Product Identification Number (PIN) to bill PharmaCare for methadone dispensed to patients on the methadone program; the PIN for a narcotic compound for pain control was used, rather than the methadone-maintenance PIN.

Additionally, Mr. Rands billed PharmaCare for both the standard dispensing fee for providing a narcotic compound for pain and the monthly capitation fee that was then in place for methadone-maintenance prescriptions. Mr. Rands also grossly overcharged PharmaCare for the methadone ($0.50/ml versus the $0.26/ml allowed by PharmaCare).

In reviewing the case, the panel considered the following: pharmacists hold a position of trust; PharmaCare expects pharmacists to use the correct PIN or DIN when filling a prescription; the public assumes tax dollars will not be diverted into an individual's pockets; and patients trust that all entries into their PharmaNet records will accurately reflect their medication history. By altering the PIN for methadone, all of Mr. Rands' methadone patients ended up with inaccurate medication records, which could have placed them at risk.

The panel found that Mr. Rands significantly breached the trust that is afforded to health professionals. It did not accept Mr. Rands' argument that intimidation by his partner and the hope that PharmaCare would quickly catch the incorrect billing led to his silence about the fraud. The panelists agreed with the judge's view that Mr. Rands' silence enabled the fraud to continue. In addition, they found Mr. Rands' actions contravened value one of the Code of Ethics:
A pharmacist respects the professional relationship with the patient and acts with honesty, integrity and compassion.

Mr. Rands' behaviour was found to be inexcusable and unacceptable.

The panel did consider a number of mitigating factors in this case: Mr. Rands pleaded guilty, accepted full responsibility for his actions, served jail time, and made full restitution of the monies owed to PharmaCare. He also significantly contributed to the practice of pharmacy for more than 30 years and this was his first serious offence. Mr. Rands' record with the college had been unblemished and he is truly remorseful for his actions.

The panel decided to suspend Mr. Rands' registration as a pharmacist for a period of 12 months commencing February 22, 2006. He will also be responsible for discipline-hearing costs.

PDAP ORIENTATION ANYONE?

Sessions underway across B.C.

Have you logged on to the college's website to register for a PDAP orientation session? If you were selected to take part in Cycle 2, join your colleagues at one of the sessions listed below. Pharmacists from Vancouver Island, the Kootenays, and the Lower Mainland have already attended a session in their area to find out more about taking part in the college's continuous quality assurance program.

All orientation sessions:

- Are free to attend.
- Take place from:
  6:30-7:00 p.m. (light supper).
  7:00-9:30 p.m. (orientation session).
- Are facilitated by a practising B.C. pharmacist and a professional facilitator.
- Provide an overview of the PDAP process, along with supporting materials.

www.bcpharmacists.org

PDAP

Orientation Sessions

15 May	Burnaby, Executive Hotel & Conference Centre
16 May	Surrey, Sheraton Guildford
30 May	Victoria, Harbour Towers Hotel & Suites
1 June	Kelowna, Ramada Lodge Hotel
5 June	Burnaby, Executive Hotel & Conference Centre
7 June	Vancouver, Holiday Inn Vancouver Centre
8 June	Terrace, Best Western Terrace Inn
12 June	Abbotsford, Ramada Plaza & Conference Centre

PHARMACY ELSEWHERE: CALIFORNIA

California's Board of Pharmacy now requires a physical description of dispensed prescription drugs on container labels. Consumers must be able to read a summary of their medication's colour, shape, and any identifying text or numbers that appear on a pill. The board's newsletter provides this example: "A label for Pravachol® might include, 'Square yellow tablet, Side 1: P, Side 2: PRAVACHOL 20.'"

The regulation requiring physically descriptive prescription labels has been in effect since 2004, but the board is pushing all pharmacies to take part by mid 2006. There are some exceptions to the labeling requirement, including: veterinarian-dispensed drugs; medications for which no physical description exists in a commercially-available database; drugs that have only been on the market for three or four months; and drugs administered in hospitals and care facilities.

Source: *The Script* (California Board of Pharmacy), January 2006

CANADA, U.S. EYE JOINT DRUG-APPROVAL

Will they or won't they? Health Canada and the United States Food and Drug Administration are assessing whether or not joint drug reviews would speed up the flow of new products from laboratories to pharmacy shelves.

Earlier this year, the initiative appeared briefly in the media, and a Health Canada spokesperson offered a cautious hypothesis: "You're exploring the possibility of real-time dialogue with the FDA. It is broadening the expertise, the perspective of product reviews," which "could ultimately lead to joint review."

While Health Canada and the FDA have similar approval processes for new drugs, products take half as much time to gain approval in the U.S., which has more drug-approval resources than Canada. The proposal is similar to one between the United States and Australia.

Canadian health-care stakeholders have varying opinions about dual approval. Rx&D, the representative body for brand-name manufacturers, supports a bi-national drug clearing process. But Dr. Joel Lexchin, a health-policy professor at York University, said while the plan might be beneficial in getting new therapies to patients sooner, he wondered if U.S. issues, such as the FDA's reluctance to approve greater access to PlanB® emergency contraception, could overshadow Canadian drug policy needs.

Source: *National Post*, February 28, 2006

Sign up and win!

Positive response to new e-Services feature

If you haven't already done so, now is the time to update your email address with the college. Join the hundreds of other CPBC registrants who want the college to use their home or work email address for correspondence. And every registrant who logs on to e-Services and changes their email address has a chance to win $100!

Just follow the simple steps in the "Prefer to use your own email address? Let us show you how!" letter the college mailed in early March. Response to the letter has been very positive. By April 27, over 600 registrants used the e-Services feature on the college website to update their email address. And remember, e-Services offers several time-saving online processes. Click on the e-Services icon at www.bcpharmacists.org to:

- Access PDAP (including orientation session sign up and PDAP 2006 Cycle registration).
- Update your name, email address, telephone and fax numbers, home address, and primary employer information.
- Pay your annual registration renewal fee.
- Donate to BC Pharmacists Benevolent Society and Canadian Foundation for Pharmacy.

Medical marijuana rolls along

Health Canada prepares pilot project materials

At a meeting in Ottawa in February 2006, Health Canada met with pharmacy organizations from across the country to get feedback on its plans for a pilot project that would see medical marijuana distributed through community pharmacies. Health Canada has agreed to develop detailed criteria and sample policies and procedures for pharmacies wishing to provide medical marijuana to patients authorized to use it through the federal Medical Marijuana Access Regulations. The college is investigating provincial policies and legislation to determine if any changes are required. Pharmacies will be notified when more information, including details on a medical marijuana-training package, become available.

Methadone maintenance file

Doses, docs, and Subutex®

Missed doses

Have you ever had a patient on methadone who has missed a few doses, either because their prescription ran out, or they couldn't get to the pharmacy? Missed doses must be reversed on PharmaNet before the end of the business day. If a patient misses methadone doses, their tolerance to opioids will decrease and it can be dangerous to provide them with their full dose the next time they come in. Be sure to inform the patient's physician about missed doses. You don't always need to speak directly to the physician; you could send a fax to let them know about the lapse. You do need to discuss the situation with the physician before giving the patient their next dose. The physician may want to see the patient before the next dose is given.

The BC Methadone Maintenance Treatment Program: Information for Pharmacists includes forms that can be used to facilitate communication with physicians. For example, appendix F can be used to inform the prescribing physician of missed doses. The document is available on the CPBC website.

Go www www.bcpharmacists.org/resources/pdf/methadonemaintenanceprogram.pdf

Requests for extra doses

Replacement for lost, stolen, or misplaced methadone "carries" cannot be provided and doses should not be provided to patients once a prescription has run out. If a patient asks for additional or replacement doses, assess the situation, evaluate the need for a replacement dose, and discuss it with the prescribing

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Methadone file

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physician. Direct communication with the physician is required and a new prescription should be written if replacement medication is to be dispensed. If any exceptions are made, the reasons must be documented in detail and communicated with the physician.

Trouble contacting a physician?
Not all information needs to be communicated to a physician immediately; sometimes sending a fax is all you need to do. However, if a prescription runs out or a patient asks for additional doses, you will need to talk to a physician immediately. Physicians must be accessible to pharmacists for dealing with urgent patient concerns. If you can't get through to a physician about a methadone-related problem, you may phone the College of Physicians and Surgeons of B.C. at 604-733-7758, extension 2314, for assistance. Messages left at this number during business hours are answered within 15 minutes.

Prescriber restrictions
In March 2006, fanouts were sent notifying pharmacists of a new feature: PharmaNet would reject methadone prescriptions unless the physician had the appropriate approvals to prescribe methadone for pain or for maintenance. However, that feature was removed to provide more time to communicate this change to pharmacists and physicians. You will be advised before it is reactivated. In the meantime, be sure that you are using the correct College of Physicians and Surgeons prescriber ID and correct methadone PIN for all prescriptions. This will ensure that when the feature reappears, it will not interfere with your ability to take care of patients' needs.

Buprenorphine (Subutex®)
In the January/February 2006 issue of *ReadLinks* we told you about buprenorphine (Subutex®), a new treatment option for opioid addiction. Although the manufacturer of the product is actively working with Health Canada to make buprenorphine available, it is still not known when this will take place. We have been given assurances that pharmacists will be informed in advance of the release of the product, to ensure adequate time for preparation and education about its appropriate use.

This column prints questions and answers from the OnCall Information Line
Toll free 1-800-663-1940

OnCall PHARMACIST INFORMATION LINE

Questions & Answers

Q A long-time patient of mine called yesterday and asked if she could purchase some pure grain alcohol from me. She's starting up a small business and says she needs it to prepare herbal extracts. I told her that we have a supply on hand since we use it for compounding, and that I wasn't sure whether I could sell it to her. Am I allowed to sell pure grain alcohol directly to patients?

A No, according to the Liquor Control and Licensing Act, you may not sell pure grain alcohol directly to the public for any reason. Pharmacists may only purchase and possess pure grain alcohol for the following reasons in connection with the pharmacy business:

- To compound medicine.
- To use as a solvent.
- To use as a preservative.
- To sell to physicians and hospitals as a sterilizing agent.

www.pssg.gov.bc.ca/lclb/

Q I read about buprenorphine (Subutex®) in the Jan/Feb 2006 issue of *ReadLinks*. Is it available on the market now?

A Although the manufacturer of the product is actively working with Health Canada to make buprenorphine available, it is still not known when the product will be available. We have been given assurances that pharmacists will be informed in advance of the release of the product, to ensure adequate time for preparation and education about the appropriate use of this product.

Q A wholesaler sent me a message stating there is a legislation change in all provinces (except Quebec) related to the scheduling of pseudoephedrine products. I wasn't aware that there was any change in B.C. Can you please provide some clarification?

A In April 2006, provinces that follow the National Drug Scheduling Advisory Committee's recommendations moved single entity ephedrine and pseudoephedrine products to Schedule II status, and multi-entity ephedrine and pseudoephedrine products to Schedule III status. However, B.C. uses a different drug-scheduling process. Therefore, these changes did not take effect here. CPBC council discussed this matter at a meeting in January 2006 and decided not to recommended changes to the scheduling of ephedrine and pseudoephedrine products at this time; in B.C. these products remain unscheduled.

www.bcpharmacists.org/resources/pdf/FYI-Crystal%20Meth.pdf

Q I know the procedure to follow to destroy expired narcotics, but I'm not sure about the procedure for expired controlled drugs such as methylphenidate and dexedrine. Can you describe the process to me?

A The process is no different for controlled drugs. The steps are as follows:

1. Prepare a list of the expired drugs and quantities. Feel free to use the form available on the college website - see first URL below.
2. Mail or fax this list to Health Canada - see second URL below.
3. Sequester these drugs while awaiting authorization from Health Canada.
4. Once authorization is received from Health Canada, destroy the expired drugs in a safe manner, rendering them unusable/irretrievable. See the Sep/Oct 2005 *ReadLinks* for more information about safe destruction.
5. Retain relevant records for three years.

www.bcpharmacists.org/resources/community/pdf/destruction_request.pdf
www.bcpharmacists.org/resources/faq/#destruction
www.bcpharmacists.org/resources/cpbc/Archived_Bulletins.htm

PREPARING FOR "PARINS"

Tips for community pharmacists

Dalteparin, enoxaparin, nadroparin, tinzaparin – all low molecular weight heparins that are sometimes prescribed for patients outside of the hospital. These products can be injected subcutaneously for the prophylaxis of thromboembolic disorders after orthopedic surgeries. Some patients are taught how to do this themselves, while others may have a family member or home-care nurse do the injections for them.

Prescriptions for these products are not seen very often in community pharmacy practice. These drugs are expensive, and often come in an array of strengths and package sizes, making it tricky to get things right. The following two scenarios illustrate the kinds of difficulties patients and pharmacists can run into.

FIRST SCENARIO

A patient's problem

After my surgery, I was given a prescription for two doses of enoxaparin (Lovenox®) 40mg/0.4 ml injection. When I went to my usual pharmacy to have the prescription dispensed, they first told me they didn't have the medication on hand. Then they said they would order it in, but I'd have to pay for 10 doses, because they couldn't order just the two doses I needed. I couldn't believe what they were saying. It isn't my fault that the package size is bigger than what I need.

The pharmacist responds

We talked about this problem at a recent staff meeting, and decided that in the future we would be prepared to order the full amount and sell the patient only the amount required on the prescription. If we did this, we could email our colleagues in the area and let them know that we had a few vials available if they had any prescriptions in the future. The other thing we could do would be to find out if other pharmacies in the area had any on hand. This is a drug that we rarely see prescribed, but we may see it more often in the future, so we thought we needed a better plan to deal with these prescriptions.

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When is enough enough?

U.S. study looks at guidelines for medication withdrawal

Pharmacists take note: the following item shows that a group of U.S. physicians has cottoned on to the value of patient drug reviews. Our profession has long known that stopping an unnecessary medication can be as important as starting a new drug. What have you done for your patients' medication management lately? Maybe it is time to ensure that checking for superfluous meds is on your patient-care check list.

Researchers from the University of Chicago published guidelines for removing a drug from a patient's regimen in the March 27, 2006 issue of the *Archives of Internal Medicine*. The researchers, all physicians, believe the following factors need to be considered, particularly with elderly patients: life expectancy, care goals, treatment targets, and time-to-benefit.

Lead author Dr. Holly Holmes said her team's framework was designed to help patients and health-care providers "decide when to stop taking even safe and effective drugs in situations that are often radically different from those where the medications were started." The "road map" as Holmes describes the study, is designed to "steer people away from the prescribing cascade that is common for patients late in life and guide them past the barriers that prevent removal of treatments that may no longer be effective."

The physicians began their study after reviewing algorithms used in prescribing drugs and preventing drug interactions in elderly patients. In one instance, accepted medical guidelines suggested a patient under one author's care was a candidate for statin use. However, the patient was over 100 years old, physically frail, and dealing with advanced cancer.

As the authors reviewed the geriatric algorithms, they noticed that none considered when medications that might have previously been appropriate should be discontinued. An example the authors use is a drug for elevated cholesterol; it may be entirely appropriate for a relatively healthy 65-year-old to take this medication, but in the next 25 years, both patient and care-giver should assess if potential side effects and treatment cost warrant continued use.

The authors' guidelines include four criteria for adding or subtracting drugs within an elderly patient's regimen:

- Calculate the patient's life expectancy – begin with actuarial charts and factor in the patient's current health status and history.
- Establish time-to-benefit ratio – an analgesic may make sense due to quick relief, but benefit from something like a statin may take months or years.
- Consult with the patient and family – consider care goals, treatment, and palliation.
- Define treatment targets – what is the desired relief, and how can this be achieved?

According to co-author Dr. Caleb Alexander, "Medication discontinuation, when done right, can decrease costs, simplify prescription regimens, decrease adverse drug events and focus therapy for maximum benefit." Study leader Holmes added, "The discontinuation of medications is a neglected science."

Source:
www.newswise.com, accessed March 29, 2006

Go www http://archinte.ama-assn.org/

Chronic pain

continued from page 1

4. Get to know patients who regularly bring in opioid prescriptions.

Most pain patients, after bumping around a sometimes-uncaring health-care system, are delighted to have a health professional take an interest in them. You can diplomatically ask why the patient is taking the pain medication when you counsel them. If you get a negative reaction, it could mean the patient has had a poor experience with a pharmacist in the past. I belong to an online chronic-pain support group and one of the most popular topics under discussion is "Why I Hate Pharmacists." Everyone complains about "The Look" – that glare of suspicion and hostility that pharmacists shoot at patients with an opioid prescription.

5. Be aware of the physical challenges of your patients.

Often when I limp into a pharmacy, I'm surprised to find that there is no place to sit down. Sometimes there's hardly room to stand. This makes waiting for prescriptions very difficult but, like many people who take opioids, I don't drive anymore; returning to pick up a prescription may not be possible, and I am forced to stand, wedged up against a shelf of cough syrups, and wait for my prescription to be filled.

6. Try to practise empathy with everyone.

How would you feel if you had to go into a pharmacy with a prescription for methadone, or OxyContin®? Could you cope with the stigma of taking chronic opioids? Think how you would feel if you were in pain and suffering from multiple side effects, and someone treated you like a drug addict every time you picked up your medication.

When I was practising pharmacy, I thought I always kept in mind the saying, "There but for the grace of God go I." Having been on the other side of the pharmacy counter, I now realize how little understanding I had of my patients and their conditions. I hope I keep the thoughts I've shared in mind when I get back on the pharmacists' side of the counter.

what went wrong

Dear college,

My allergist prescribed a drug to help with the severe itchiness I sometimes get all over my body. I got the medication from the pharmacy and took one to two tablets each night, as directed on the label, over the next three months.

When I went to the pharmacy to order a refill, I found out that a dispensing error had been made. I had been taking hydrochlorothiazide, a drug used for high blood pressure, for the last three months!

I've read on the Internet that hydrochlorothiazide can cause dehydration, low potassium, low blood pressure, and high blood sugar. Thankfully, I haven't noticed anything unusual over the past three months, but if the error had never been noticed, I would have received a refill of the wrong medication too, and taken it for another three months.

Horrified about hydrochlorothiazide

The pharmacist involved reports:

- The prescription was clearly written for hydroxyzine 25mg tabs, 1-2 tabs po qhs as needed, 60 tabs.
- "The prescription was written for 'tabs.' Hydroxyzine is customarily ordered as capsules. I inadvertently misinterpreted and processed this prescription as hydrochlorothiazide."
- When the patient ordered a refill of her "itching medication," the error was identified.

What steps could be taken to prevent such a situation?

1. Always ask yourself about the appropriateness of therapy, dose, route, frequency, duration, and dosage form before dispensing. In this case, answering these questions may have assisted with detection of the error:
   a. Is it appropriate to take hydrochlorothiazide at bedtime?
   b. Is it appropriate to take hydrochlorothiazide on an as-needed basis?
   c. Is it appropriate to take 25-50mg of hydrochlorothiazide as a starting dose?
2. Pay attention to the prescription's details. In this case, the prescription pad was pre-printed with "ALLERGY & CLINICAL IMMUNOLOGY." At other times, prescribers may include the drug's indication. This provides another opportunity to confirm that you are dispensing the right drug.
3. Involve two pharmacists in the dispensing process – one to process the prescription, and another to perform a final check. If this is not possible, step away from a prescription and try to clear your mind before conducting the final check.
4. When performing the final check, adopt the attitude that there is something wrong with the label and that it is your job to find the problem. First examine the written prescription and "set in your mind" how the label should read. If you check the product the other way, and read an incorrect label first, it might "set in your mind" that the label is correct.
5. Always provide thorough patient counseling before the patient leaves the dispensary. In this case, if the pharmacist had explained that hydrochlorothiazide is a diuretic used to manage high blood pressure, the error may have been caught. Likewise, if the pharmacist had prompted the patient to answer why the medication was prescribed, the error may have also been caught.

DRUG UPDATES

For full details please check:

www.napra.ca or
www.bcpharmacists.org

- Pseudoephedrine products availability.
- Evra® contraceptive skin patch.
- Counterfeit and unapproved avian flu products.
- Potential delivery of unrequested patient-controlled analgesia (PCA) infusion pump doses.
- Newer antidepressants linked to serious lung disorder in newborns.
- Hydrea® (hydroxyurea capsules).
- Trasylol®.
- Emagrece Sim™ (Brazilian diet pill) and Herbathin™.
- Tequin®.
- Octreotide Acetate Omega® 500 mcg/ml product recall.

PREPARING FOR "PARINS"

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SECOND SCENARIO

A pharmacist's discovery

One of our patients had knee replacement surgery and got a five-day supply of nadroparin (Fraxiparine™) from the pharmacy closest to the hospital. We are his regular pharmacy and when he came home, we called the first pharmacy for a transfer. The pharmacist told us that the prescription was for 9500 units, one syringe daily, so we ordered 9500 unit 1 ml syringes.

When the patient came in he realized that the size of the syringe was bigger than before. He looked at one of his old syringes and saw that he'd had 0.6 ml syringes – 5700 units per dose. It turns out that the product is available in five sizes – with a concentration of 9500 units/ml, and all have the same DIN. It is also available in 19,000 units/ml in three sizes.

A suggested solution

When transferring prescriptions, be sure to provide the complete information including the patient's dose. And enter the patient's daily dose into PharmaNet, so that other pharmacists have the complete information.

Rx drug program helps oncology patients

Financially strapped can get assistance for key meds

Do you have an oncology patient facing financial hardship that may impact their access to life-saving meds? If so, your patient may be interested in finding out if they are eligible for the Emergency Aid Drug Program (EADP). This program, jointly operated by the BC Cancer Agency (BCCA) and the Canadian Cancer Society (CCS), provides certain patients with a year's worth of financial assistance to cover supportive-care medications.

Eligibility

Patients under active care of an oncologist and receiving BCCA-approved cancer treatment (curative or life extending) are eligible to receive EADP benefits. The first step for patients is to have a financial assessment performed by the CCS. EADP benefits are intended to assist patients for a period of one year; requests to extend the benefit period are evaluated on a case-by-case basis and must meet stringent criteria. It is important for patients, and families, pharmacists, and other caregivers, to recognize that the EADP is a program of last resort. Expectations are that all other possible resources, including third-party insurance, are used first. Patients qualifying for PharmaCare Plan P (palliative care) are not eligible for EADP benefits.

Drug benefit list

EADP medications are determined by the BCCA, and are limited to those primarily used in supportive care of patients undergoing active treatment. The EADP drug benefit list includes some of the same drugs available through PharmaCare's reference-drug and LCA programs. The EADP assists patients in meeting their PharmaCare deductible levels only. All EADP patients must have registered for Fair PharmaCare and all drugs requiring a PharmaCare special authority have the same requirements for EADP. Generally, EADP covers the same prescription items as PharmaCare. In some instances, non-benefit prescription drugs may be considered for partial coverage as long as Fair PharmaCare and PharmaCare special authority requirements are met. Pharmacists can obtain further information and approval for their patients by contacting a BCCA EADP pharmacist. The EADP benefit drug list is available on the BCCA website at www.bccancer.bc.ca/RS/CommunitiesOncologyNetwork.

Getting started

In order for EADP patients to access benefits through a community pharmacy, that pharmacy must be able to accept payment by MasterCard for the BCCA share of the drug costs – no other payment mechanism is currently available. Detailed process instructions have been provided to many community pharmacies in B.C., and are posted on the BCCA website at www.bccancer.bc.ca/RS/CommunitiesOncologyNetwork. Patients who want to know if they qualify for EADP can call the nearest Canadian Cancer Society regional office, log on to the CCS website, or call 1-888-939-3333 for more information.

www.cancer.ca

Robert Sindelar and Marshall Moleschi are geared up for a visit to the Fort St. John Medical Clinic, part of the recent UBC/CPBC/BCPhA visit to pharmacists and pharmacies in north-east B.C.