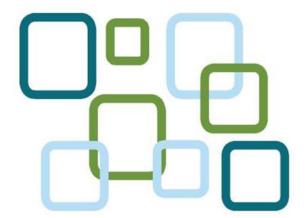
How do pharmacies dispense to patients going on vacation for an extended period? (Requesting a larger quantity than the returned quantity?)

When dispensing additional doses, instruct the patient to return the total number of patches they received in their last order.

Also, they may require additional return sheets at that time. If they are receiving a larger quantity than usual, they must return the same number in order to receive the next lot, even if the prescription is for a smaller quantity than the current prescription. It will be important to document the changes.

What if the patient had a previous prescription filled at a different pharmacy and brings their current prescription to our pharmacy?

If the prescription is ongoing and changing from another pharmacy, the patient should be instructed to bring in their old patches (on the brochure) before receiving their new ones. The number of patches dispensed can be checked by reviewing the prescription (i.e. pharmacy) label on the patient brochure/return sheet.



Who do pharmacies notify if there is a suspected issue with diversion?

In suspected cases of diversion, pharmacists are encouraged to refer to the Health Canada (2006) guide for health professionals called 'Abuse and Diversion of Controlled Substances'.

What do pharmacies do if they suspect someone is handing in counterfeit patches?

Advise the patient that it is an indictable offense to unlawfully obtain opioids and that they must bring in all the actual patches before dispensing new ones

If you have any question of comments, please contact the Grey Bruce Health Unit at 519-376-9420 or 1-800-263-3456

Some of the information in the Grey Bruce FAQ resource was adapted from a similar FAQ resource from Oxford County.





Resource for Health Care Professionals

# What is the Grey Bruce Fentanyl Exchange Program?

The new Grey Bruce Fentanyl Patch 4 Patch Program asks physicians who prescribe, pharmacists who dispense, and patients who use fentanyl to work together and prevent fentanyl misuse and abuse in the community.

The ultimate goal is to keep fentanyl in the hands of patients who are prescribed it with the intent to increase community safety.

### THE PROGRAM...

Provides patient education to increase the safe, effective, and responsible use of Fentanyl patches. Education starts in the physician's office and continues at the pharmacy.

The program asks pharmacists to:

- Dispense no more than a one month supply of Fentanyl at a time to a patient.
- Provide the patient with a Fentanyl brochure/return sheet each time they receive Fentanyl patches.

- Counsel patients to return used patches.
   Explain to patients that the patch is to be placed flat on the return sheet.
- Dispense one new patch for each used one that is returned.
- Understand that although the program strongly encourages pharmacists to dispense a one month supply of patches at one time, it remains their professional discretion as to the number of patches dispensed.



#### WHAT CAN PHYSICIANS DO?

 Provide comprehensive patient education and counselling when prescribing fentanyl. Explain to their patients that they will receive one new fentanyl patch for each used patch returned.



• Explain to the patient that their used fentanyl patches are to be returned to their pharmacy and not to their physician's office.

#### WHAT CAN PHARMACISTS DO?

• Monitor the number of patches dispensed and returned by patients. Work with each patient to dispense one new patch for each used patch returned.

## **FAQs**

#### Are pharmacists required to comply?

A prescription is essentially 'a permission' for a particular product to be dispensed to a patient. When a physician writes a prescription for Fentanyl that includes specific instructions for the pharmacist, it is expected that the pharmacist will follow or adhere to those instructions (if it's in the best interest of the patient.) A pharmacist is expected to use their professional judgement whenever they are involved in patient care activities.

Will the Ontario College of Pharmacists support your pharmacy's participation?

The Ontario College of Pharmacists (OCP) is in favour of professional activities that support patient care and protect the public interest. The Grey Bruce Patch 4 Patch Program is designed to support the safe disposal of high alert medication after its therapeutic use has finished. Therefore we expect the OCP will support this program and the pharmacists who participate.

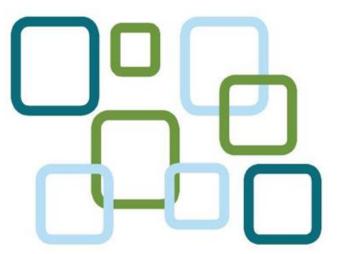
OCP does not currently have a best practice recommendation on this matter. However, there are parallels to some of the policies and guidelines that pharmacies adhere to when dispensing methadone. Those guideline are available at <a href="https://www.ocpinfo.com/regulations-standards/policies-guidelines/methadone2/">www.ocpinfo.com/regulations-standards/policies-guidelines/methadone2/</a>

What are the program resources and how do they work?

The program provides pharmacies with:

- A Fentanyl patient brochure/return sheet. The brochure is intended to supplement pharmacist counselling about the responsible and safe use of Fentanyl. The brochure also instructs patients to place their used patches on the brochure (in the empty squares) and return the brochure with the used patches to the pharmacy. The brochure explains to patients that they will get one new patch for each used one they return.
- A patient tracking form (used at the discretion of the pharmacy.) Some pharmacies use a patient tracking form to monitor the date and number of Fentanyl patches dispensed and the date and number of patches returned.

If you pharmacy want to use a patient tracking form please contact the Grey Bruce Health Unit at 519-376-9420 or 1-800-263-3456.



Won't the patient be short on one or two patches the first time they return their brochure?

Yes, once the program starts and the patient returns their brochure for the first time they will be short one or two patches. This is because when they return to the pharmacy to get a refill or pick-up a new Fentanyl prescription, the patient would, from the previous pick-up, be using one patch and/or keeping one unused patch in the medicine cabinet. They can return the one of two missing patches on their next visit. Subsequently, the patient would be expected to receive one new patch for each unused on.

How do pharmacies handle a situation where a patient brings back eight out of ten patches?

In this case, the patient gets eight new patches. Remind the patient that when they received their ten new patches they were made aware that, when they returned to the pharmacy for a refill or to fill a new prescription, they would get one new patch for every used patch returned.

If the number of patches is short with the first return, the patient should be reminded of the need to return the patches. If it happens again, it's strongly suggested that the patient be referred to their physician to discuss if fentanyl is the best option for them.

What should pharmacies do with the used patches?

The sheets of used patches should be disposed of in the pharmacies Stericycle container.