2 March 2018

Technical and Safety Improvement Section
Pharmacovigilance and Special Access Branch
Therapeutic Goods Administration
PO Box 100
WODEN ACT 2606

Dear Therapeutic Goods Administration,

RE: Consultation on Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response

The Society of Hospital Pharmacists of Australia is the national professional organisation for more than 5,000 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system. SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals.

SHPA is pleased to see that recent regulatory action on the scheduling of codeine-containing medicines has evolved into a broader discussion on opioids. Research from the Pennington Institute has found that the use of opioids in Australia has quadrupled from 22 million doses prescribed to patients in 2001, to 106 million doses in 2016.[1] As hospital pharmacists, SHPA members often see the worst of opioid misuse and abuse in inpatient wards and in emergency departments.

Hospital pharmacists are judicious clinicians with respect to supply of opioid medicines, often advising doctors of appropriate pain medicine prescriptions, pain management plans and opioid de-escalation plans. Hospital pharmacists are also represented on Acute Pain Service teams and are the leading clinicians in emerging opioid stewardship services.

In response to the TGA's proposed options for a regulatory response SHPA believes that Options 1, 2 & 3 should be prioritised as they would have the largest impact on medical and pharmacy practice to reduce inappropriate opioid use in the community. SHPA members are highly engaged with this area of practice and made a wide range of comments which are summarised below.

Highest priorities:

Option 1: Consider the pack sizes for strong (S8) opioids

SHPA support consideration of the provision of smaller pack sizes of strong opioids to patients as appropriate, as already commonly occurs at discharge from hospital.

Research conducted by the Centre for Disease Control in USA has demonstrated that the quantity of opioids supplied on initial prescription positively correlates with probability of prolonged use of opioids. Patients receiving initial opioid prescription of one-day supply only had a 6% chance of being on opioids for a year or longer, compared with 10% chance for

patients supplied with five-days supply. Patients receiving 14-days supply, which is the standard pack-size for sustained release opioids in Australia, had a 25% chance of remaining on opioids one year later.[2]

We recognise the challenge of treating and managing pain whilst reducing the risk of misuse, diversion and dependence. Simultaneously, the risk that patients are unable to access timely community care to ensure review and additional prescription if required, can provide a perverse incentive for larger pack size supply.

SHPA notes that it is much more commonplace in hospitals to give partial packs of medicines commensurate to clinical need, in comparison to retail pharmacies who are traditionally reluctant to break up packs. At present, a pack of sustained-release opioid medicines typically come as 14-days' supply in Australia (i.e. Targin, Oxycontin, MS Contin), however hospital pharmacists typically supply less than pack quantities, instead supplying quantities clinically appropriate for patients, and encouraging non-opioid analgesics and non-pharmacological interventions to treat pain where possible.

Although prescribers and pharmacists are well within their remit to prescribe and supply less than the stated pack size or prescribed quantity, this has not been sufficient or adequate to curb rising opioid misuse. SHPA believes that medicines sponsors should register smaller pack sizes of opioid medicines on the ARTG. To incentivise the supply of smaller pack sizes for opioid medicines for patients, the PBS must implement a review of availability of larger pack sizes and their appropriateness, to discourage unnecessary prescribing and dispensing. Strategies that must be considered for implementation in parallel include pricing incentives for smaller quantities and patient co-payments that do not disadvantage patients for obtaining smaller quantities.

In particular, SHPA strongly supports the introduction of smaller pack sizes of oral liquid formulations. A common issue is the supply of oral liquid formulations of Schedule 8 opioid medicines where the PBS-funded quantity is a single pack. This is a safety issue for patients at discharge and also a necessary clinically for treatment for geriatric and paediatric patients. Supplying part packs (i.e. repacked 20ml bottle) renders these medicines ineligible for PBS subsidy. Examples include medicines such as oxycodone 1mg/mL available in 250mL, and hydromorphone 1mg/mL available in 473mL.

If a greater range of pack sizes or smaller pack sizes were introduced, SHPA believes prescribing software should be reviewed to stop the current practice of prescriptions defaulting to the maximum PBS-funded quantity. SHPA member feedback has reported that re-programming of the hospitals' electronic medication management system to set the default quantity of immediate release oxycodone release tablets to zero, coupled with targeted prescriber education, has led to an overall decrease in supply of immediate release oxycodone by the hospital.

Option 2: Consider a review of the indications for strong (S8) opioids

SHPA strongly agrees that a review of the indications for Schedule 8 opioids should be conducted to ensure that the products and strengths available for prescribing and dispensing are commensurate with best practice guidelines and current evidence. The outcomes of

these reviews should also result in Product Information and Consumer Medicine Information resources being updated to reflect evidence-based practice. The findings should also inform PBS restrictions placed on these medicines such that they are not prescribed and dispensed inappropriately. For example, sustained released opioids are not recommended for use in the treatment of acute pain according to current practice guidelines, but members observe these medicines are regularly prescribed to treat acute pain.

SHPA members typically refer to Therapeutic Guidelines: Analgesic and clinical guidelines by various peak medical colleges to guide their practice and prescribing advice to prescribers. In hospitals, clinical pharmacists are regarded as medicines experts and regularly provide education to nurses and allied health practitioners as well as prescribing advice to doctors in line with best practice and current evidence. Pharmacists are also integral to hospital services that manage patients with complex pain management such as acute pain services and opioid stewardship programs.

Option 3: Consider whether the highest dose products should remain on the market, or be restricted to specialist/authority prescribing

SHPA believes there are potential merits to further restrictions for high dose opioid medicines, such as specialist/authority prescribing, and this warrants further consultation. Australian analysis of PBS data has linked the increased use of opioids in the population with the availability of PBS-subsidised long acting opioid formulations for treatment of non-cancer pain[3]. SHPA believes that a review of indications and clinical evidence for high dose opioids is justified, however further restrictions to prescribing must be evidence-based and should also not become a significant regulatory burden on prescribers and pharmacists.

SHPA understands that at present, the only restrictions for opioid prescribing is that jurisdictional health authorities require prescribers to obtain permits to treat patients continuously for more than two or three months. Nationally there are currently extra regulatory requirements for high-risk medicines such as clozapine, thalidomide, clomiphene and others, noting that inappropriate use can cause significant harm. Any additional regulatory safeguards need to be appropriately balanced with any potential administrative burden for patients, prescribers and pharmacists, as well as the availability of specialist physicians, especially in rural and remote areas where chronic pain is more prevalent. While SHPA respects the jurisdictional nature of drugs and poisons regulation, harmonising permit requirements and regulations nationally would complement any further regulation implemented by the TGA.

Another potential option is to restrict the prescribing of these medicines according to the type of patient and their pain condition (chronic, acute, cancer-related pain etc) and the type of prescriber (general practitioner or specialist). These types of restrictions are currently implemented through the PBS funding model for high risk medicines and expensive medicines and have improved the quality use of medicines. However, anecdotal evidence suggests that these regulations are curbed by off-label prescribing which are often not detected by PBS mechanisms. The introduction of real-time prescription monitoring nation-wide would be able to capture off-label, non-PBS prescribing of opioids.

If prescribing of opioids is circumscribed, pharmacists must be adequately recognised and supported to monitor access and supply of opioids. For example, for Victorian pharmacists to verify if prescribers for patients treated with long-term opioids have the relevant permits they must telephone the Department of Health and Human Services, which is resource-intensive. SHPA believes that as real-time prescription monitoring continues to be implemented by national and jurisdictional governments, it is possible these systems can also act as a portal for administering and reviewing these permits to provide administrative efficiencies for all involved.

Secondary priorities:

Option 4: Strengthening of the Risk Management Plans for opioid products

SHPA would support the strengthening of the Risk Management Plans with sponsors of opioid products, which would include greater education and training of healthcare professionals, as well as communication to patients. SHPA regularly provides educational content to our members, including a pain management seminar for hospital pharmacists, and is well placed to be a repository of educational content related to opioid medicines delivered to the hospital pharmacist community.

Option 5: Review of label warnings and revision to Consumer Medicines Information

SHPA would support a review of label warnings and revision to Consumer Medicines Information to highlight the risks and cautions for patients. This needs to be balanced to not cause alarm and potential non-adherence for patients. SHPA would also support the availability of plain English resources and in languages other than English.

Option 6: Consider incentives for expedited TGA review of improved products for pain relief and opioid antidotes

SHPA supports incentives for expedited TGA review of improved products for opioid antidotes. SHPA notes that naloxone became a Schedule 3 Pharmacist Only medicine in 2016, meaning Australia is only the second country in the world to allow access to this life-saving product without a prescription.

However, anecdotal evidence suggests that the listing of improved products is not enough to change supply behaviour. Naloxone is often not stocked by community pharmacies, and patient cost remains a barrier. SHPA recommends co-prescribing and dispensing of naloxone to patients at risk of overdose and misuse, noting that co-prescription of naloxone with opioids for at-risk patients is commonplace in various states in the United States of America. A PBS-listing for naloxone would also improve its affordability for patients, but we note that it is incumbent on the sponsor to make a PBS listing application.

SHPA conditionally supports expedited TGA reviews of improved medicine products for pain relief depending on what type of analgesics the TGA is referring to. For example, these incentives should not be applied to other opioid medicines which continue to exacerbate the current rates opioid use. This has been observed by the introduction of tapentadol into Australia.

Any new medicines that may undergo expedited review must be evidence-based, cause less harm and dependency than opioid analgesics and have undergone rigorous assessment for safety.

Further consideration is required for Option 6, as the range of potential medications that's could be classified as 'for pain relief' is wide and could include non-steroidal anti-inflammatories, COX-2 inhibitors, gabapentinoids and selective serotonin reuptake inhibitors for example. These may precipitate much lower levels of dependency, but are capable of producing other toxicities and may not be appropriate for expedited TGA review.

Option 7: Potential changes to use of appendices in the Poisons Standard to provide additional regulatory controls for strong S8 opioids

SHPA supports the dissemination of greater information about medicine use and safety, however member feedback is limited on its effectiveness in behaviour change. Appendices cover a wide range of options including labelling, advertising, warning statements and therefore further consultation would be required. Any additional regulatory controls must support medication safety and quality use of medicines principles, while not causing impractical regulatory burden on doctors and pharmacists that significantly detract from direct patient care. It is important to consider that additional or changed regulatory controls may encourage a greater level of coordination and communication between state, regulatory and federal agencies.

Option 8: Increase health professional awareness of alternatives to opioids (both S4 and S8 opioids) in the management of chronic pain.

SHPA would support increasing health professional education and awareness of alternatives to opioids in the management of chronic pain, as well as evidence-based non-pharmacological treatments.

Hospital pharmacists are aware of the risks and harms of opioid use and as a matter of practice, strive to cease opioids where possible or use the lowest possible dose to manage a patient's pain. During patient counselling sessions, hospital pharmacists educate patients about the importance of regular non-opioid analgesic use to minimise the need for opioid analgesics. Hospital pharmacists also educate patients about non-pharmacological treatments to complement their pain management, such as massage, light exercise meditation and relaxation techniques.

Other matters:

- **Real-time prescription monitoring systems**

To strengthen the impact of the regulatory options undertaken by the TGA, they must be considered in the context of real-time prescription monitoring (RTPM) systems which are being developed and implemented across Australia. Tasmania, Victoria, ACT and the federal government have committed to build systems with other jurisdictions planning to act. Hospital pharmacists and hospital pharmacies are critical to ensure the success and policy

achievement of any RTPM system, and hospital stakeholders such as SHPA must be consulted with in their development. In certain states, hospital pharmacy stakeholders have not been represented on expert advisory groups to develop RTPM systems, which has lead to specific issues regarding interoperability with hospital pharmacy dispensing software and delineation between outpatient and inpatient supply, being discussed too late into their development.

Further, as mentioned above, these systems could act as a repository for validity of prescriber permits of long-term opioids, as well as recording any further specialist/authority prescriber restrictions.

- **Prescription validity**

A concern not addressed in the consultation is opioid prescriptions being valid for up to twelve months, whereas some states have six months validity. It is inappropriate that pain medicines meant to be used to address acute pain can have a validity for up to twelve months, well after the acute pain is expected to subside. SHPA believes the prescription validity timeframes should be reviewed to align them with pain management plans and treatment goals. Prescribers should also be empowered to endorse prescriptions with a shorter expiry date where relevant.

SHPA believes that Options 1, 2 & 3 should be exercised by the TGA as a matter of priority. These options will alter medical and pharmacy practice and will lead to safer, appropriate prescribing and supply of opioid analgesics. SHPA members are highly engaged in this practice area given the prevalence of pain among hospital inpatients and are valued members of the multidisciplinary team whose expertise is regularly called upon. SHPA welcomes the opportunity to work with the TGA closely in implementing these options.

If you have any queries or would like to discuss our submission further, please do not hesitate to contact [redacted]

Yours sincerely,

[redacted]

References

[1]Pennington Institute (2016). Australia's Annual Overdose Report 2016. Available at: http://www.penington.org.au/overdoseday/
[2] Shah A, Hayes CJ, Martin BC. (2016) Morbidity and Mortality Weekly Reports - Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm#F1_up
[3] Karanges E, Blanch B, Buckley N, Pearson S. (2016) Twenty-five years of prescription opioid use in Australia: a whole-of-population analysis using pharmaceutical claims. Br J Clin Pharmacol, 82: 255–267. doi: 10.1111/bcp.12937.