

Prescribing: Drugs with Potential for Misuse or Diversion

Related Standards of Practice: [*Prescribing: Drugs with Potential for Misuse or Diversion*](#), [*Prescribing: Administration*](#)

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the *CPSA Standards of Practice*. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

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Protecting Patient and Public Safety

There are important risks associated with prescribing opioids and other drugs with potential for misuse or diversion. These risks include addiction, abuse, diversion, poisoning, overdose, impaired function, accidents and injuries.

The CPSA encourages physicians to take steps to mitigate these risks through sound clinical practice and relevant guidance, such as the [Canadian Guideline for Opioids for Chronic Non-Cancer Pain \(2017\)](#) from McMaster University and the similar [guidelines from the U.S. Centers for Disease Control and Prevention](#). These guidelines emphasize the use of therapies other than drugs with potential for misuse and diversion whenever possible.

When a medication with these risks is the best clinical option, the prescription should be for the lowest effective dose for a limited duration, in keeping with the natural history of the pathology resulting in pain. General guidelines suggest the ideal duration is three to seven days. Longer durations require clinical justification and specific monitoring of the circumstances.

When prescribing these medications, whether for very short term use or on a long-term basis, the College requires physicians to follow sound clinical practice, the core elements of which are:

- discuss with the patient the risks, potential benefits and alternatives to the medication;
- understand the individual health context, including co-morbid substance use disorder, risk factors for substance abuse, current prescribed medications by reviewing the Pharmaceutical Information Network (PIN)/Netcare or a valid alternative source, and identifying the use of other psychoactive drugs including alcohol and illegal drugs (confirming, when appropriate, by random urine drug screens);
- document a patient-physician agreement that includes the goals of treatment (improved health and function) and the anticipated duration of the treatment; and
- identify a justifiable indication for the drug treatment and, for longer-term treatment, provide periodic reassessment appropriate to the clinical circumstances, at least every three months (see [Example Scenarios](#)).

For a medical regulator to provide specific clinical guidance is rare, and means to send a larger message: safe and competent practice requires informed clinical decisions and coordination with other physicians, pharmacists, colleagues and the broader health system. We expect physicians to know what drugs their patients are taking, not just what they prescribe.

Statistics show Canadians are prescribed more opioids than patients in most other countries; we also know historically more Albertans have been prescribed opioids than patients in other Canadian provinces. Triplicate Prescription Program data further shows large numbers of Albertans are receiving high doses of opioids, multiple opioid medications, opioids from multiple prescribers and/or opioids concomitantly with benzodiazepine medications.



Whatever the historical reasons for this situation, physicians are ideally placed and ethically obligated to be part of the solution.

The College recognizes this is a very challenging area of practice and there is much uncertainty about how best to manage the complex clinical problems that often result in an opioid prescription.

The evidence about opioid prescribing is evolving and the advice in this document reflects what we know today. As more evidence becomes available, we will update this advice to address some of the unique situations physicians may encounter.

Scope of Standard

For the purpose of patient safety, College Council deliberately chose a broad scope for the standard. Any medication perceived to carry a potential for misuse or diversion falls within its scope, which includes but is not limited to: opioids, benzodiazepines, sedatives and stimulants. Physicians are expected to exercise their judgment to determine when the standard applies, considering not only the medication, but also the clinical context in which the prescribing occurs.

Refer to [Appendix A: General Medications List](#).

Example scenarios

The following scenarios illustrate how the standard would apply in various situations.

Scenario 1:

An anesthesiologist orders a single dose of benzodiazepine as a premedication for a surgical patient. Is it necessary to check the patient's medication profile prior to writing the order?

Given that only a single dose of medication is being prescribed and the medication will be administered by a regulated healthcare provider in a supervised setting, the risk of misuse or diversion in this scenario is small. The value of checking the patient's previous dispensing history may be limited; however, the anesthesiologist should be aware of the patient's current medication history to ensure there are no contra-indications or potential drug interactions.

Scenario 2:

A neurologist prescribes clobazam for a patient with epilepsy. Prior to initiating the prescription several years ago, the neurologist obtained a thorough history to rule out alcohol and substance abuse or dependence. The patient is stable and has been attending the neurologist semi-annually for follow up. Is it necessary to see the patient every three months?

Clobazam is a benzodiazepine and, as such, has the potential for misuse or diversion, albeit less than other drugs within this class. Ideally, the neurologist should collaborate with the patient's family physician to ensure the patient is followed up on a regular basis in accordance with the College's advice. If there is sufficient information to justify not assessing the patient more frequently, the neurologist should ensure the justification is adequately documented in the patient's record.

Scenario 3:

A physician accepts a patient from a retired colleague. The patient has been prescribed 2000 mg morphine equivalents a day for years. The physician believes the steps outlined in the College's standard of practice are unnecessary because the patient is stable and the physician is only continuing the treatment.

This is a high-risk scenario for both the patient and the public. Evidence confirms the risk of overdose and death increases at this dosage. Furthermore, the physician must maintain a high index of suspicion for misuse and diversion; checking PIN/Netcare is essential to ensure the patient is not receiving additional medication from other providers. The physician should familiarize him/herself with current opioid treatment guidelines and should also follow the steps outlined in the College's standard of practice and this advice document.

Prescribing Requirements

When prescribing drugs with potential for misuse or diversion, physicians are required to review the patient's medication history from PIN/Netcare:

- before initiating a prescription;
- before renewing a prescription, if the physician renewing is not the primary prescriber; and
- at minimum, every three months when the prescription is for the long-term treatment of a patient.

Random urine drug testing (rUDT) and/or random pill counts should be done at least annually for all adult patients on long-term opioids, benzodiazepines, sedatives or stimulants.

The College acknowledges not all physicians can readily access PIN/Netcare. When access is unavailable, the physician must seek an alternative source for the patient's medication profile that is independent of the patient and

the patient's family or friends. Acceptable alternative sources include a hospital or community pharmacist, or the [Triplicate Prescription Program](#). The Triplicate Prescription Program can be reached at 1-800-561-3899 ext. 4939 (in Canada) during regular office hours.

If the patient's medication profile is not immediately accessible, the physicians may prescribe only the minimum amount of medication required until the information can be obtained.

Opioid Prescribing

Refer to these guidelines:

- [Canadian Guideline for Opioids for Chronic Non-Cancer Pain \(2017\) – full guideline](#)
 - [Poster summary \(English\)](#)
 - [Poster summary \(French\)](#)
- [CDC Guideline for Prescribing Opioids for Chronic Pain \(U.S.\) – full guideline](#)
 - [Fact sheet](#)
 - [Summary of recommendations](#)

Initiating Opioid Therapy

Before initiating opioid therapy for acute or chronic pain, the physician is expected to:

- conduct a thorough assessment of the patient and ensure there is a clinically justifiable indication for opioid therapy;
- discuss non-pharmacological and pharmacological options with the patient;
- screen for addiction potential;
- check PIN/Netcare (or independent alternative source) to ensure the patient is not receiving prescriptions from other providers;
- explain the risks and benefits of using an opioid medication for the diagnosed condition and ensure the patient has enough information to provide fully [informed consent](#), and document this discussion in the [patient's record](#);
- determine the nature of the patient's work activities (if applicable), including any safety-sensitive work tasks, and counsel the patient regarding any workplace safety concerns related to the use of the medication(s) to be prescribed, including a discussion of work restrictions and limitations where a risk of impairment exists;
- establish goals for treatment and set reasonable expectations with the patient, including that opioids can reduce but not eliminate pain;
- prescribe the lowest effective dose as the risks of opioid use increase with higher doses: extreme caution is required when exceeding [recommended guidelines](#);
- NOT prescribe benzodiazepines, hypnotics and/or sedatives concomitantly with opioids;



- identify other drug use by the patient, including alcohol, illegal drugs or diverted prescription drug use;
- limit opioid prescriptions for acute pain to 3 to 7 days unless there is a justifiable indication for long-term opioid therapy, and document this justification in the patient record; and
- for prescriptions of longer duration than 7 days, reassess the patient within 7 to 10 days.

Long-Term Opioid Therapy

There are a number of conditions that cause pain and symptoms for which prescribed opioids might be considered within an encompassing program of pain modulation and pain coping strategies. Many referenced documents and standards refer to chronic, non-cancer pain.

The College encourages physicians to think about the underlying pathophysiology of pain when prescribing opioids. If a patient's condition requires pain modulation beyond the acute phase, regardless of the underlying medical diagnosis, long-term opioid therapy warrants special considerations. Even in palliative care and end-of-life situations, care and skill must be exercised to ensure optimal outcomes for patients when prescribing opioids.

Physicians are expected to:

- establish an [opioid agreement](#) with the patient;
- offer a take-home naloxone prescription if the patient is at risk of respiratory depression as a consequence of receiving opioid medications, and document the offer;
- order random urine drug testing (rUDT) and/or random pill counts at least annually if the patient is an adult;
- counsel the patient appropriately regarding any ongoing workplace safety concerns related to the use of long-term opioid treatment, outlining work restrictions and limitations as needed
- reassess the patient **at least** every three months to:
 - ensure the medication is providing effective pain relief and improved function, and to assess any side-effects the patient may be experiencing;
 - determine if the patient may be developing tolerance or an opioid use disorder;
 - confirm there is no evidence the patient may be misusing or diverting the medication. Red flags include:
 - The patient requests early refills, claims to lose the medication or provides excuses for why additional medication is needed.
 - PIN/Netcare review reveals the patient is multi-doctoring to obtain additional medication.
 - An alternate person requests the prescription from the physician.
 - Another healthcare professional reports aberrant behavior, such as a pharmacist reporting the medication is being picked up by individuals other than the patient for no justifiable reason.
- if the opioid dose exceeds current guidelines, carefully assess the patient to ensure the benefit is greater than the risk; a sound, clinically justifiable reason must be documented whenever exceeding the threshold; and

- document patient-specific interactions and prescribing approach so colleagues who care for the patient in the primary physician's absence can provide consistent care.

If the physician cannot clinically support continuation of the opioid, motivational interviewing strategies should be used to engage the patient in a [slow taper](#). When tapering is challenging, physicians may wish to consider an opioid replacement therapy such as [buprenorphine naloxone](#). Physicians unfamiliar with the use of buprenorphine naloxone should consider pursuing [continuing medical education](#).

For primary prescribers, it is never appropriate to abandon a patient on long-term opioid therapy, abruptly cut off or threaten to cut off the patient's medication.

Physicians must consider the potential risk to a patient seeking illicit opioids.

Benzodiazepine Prescribing

Benzodiazepines are highly addictive medications that can have adverse side-effects, particularly when used long-term. Physicians treating patients with long-term benzodiazepine therapy should ensure the medication is indicated and the patient is on the lowest possible dose.

Initiating Benzodiazepine Therapy

Before initiating benzodiazepine therapy, the physician should:

- conduct a thorough assessment of the patient and ensure there is a clinically justifiable indication for benzodiazepine therapy;
- discuss non-pharmacological and pharmacological options with the patient;
- screen for addiction potential;
- check PIN/Netcare (or independent alternative source) to ensure the patient is not receiving prescriptions from other providers;
- explain the risks and benefits of using a benzodiazepine for the diagnosed condition and ensure the patient has enough information to provide fully [informed consent](#), and document the discussion in the [patient's record](#);
- determine the nature of the patient's work activities (if applicable), including any safety-sensitive work tasks, and counsel the patient regarding any workplace safety concerns related to the use of the medication(s) to be prescribed, including a discussion of work restrictions and limitations where a risk of impairment exists;
- prescribe the lowest effective dose as the risks of benzodiazepine use increase with higher doses: extreme caution is required when exceeding [recommended guidelines](#).
- avoid prescribing benzodiazepines to elderly patients whenever possible;
- NOT prescribe benzodiazepines concomitantly with opioids and/or sedatives;
- limit benzodiazepine prescriptions to 3 to 7 days unless there is a justifiable indication for long-term benzodiazepine therapy, and document the justification in the patient record; and
- for prescriptions of longer duration than 7 days, reassess the patient within 7 to 10 days.

Long-Term Benzodiazepine Therapy

When prescribing long-term benzodiazepine therapy, the physician should:

- establish a [treatment agreement](#);
- order random urine drug testing (rUDT) and/or random pill counts at least annually if the patient is an adult;
- counsel the patient appropriately regarding any ongoing workplace safety concerns related to the use of long-term opioid treatment, outlining work restrictions and limitations as needed;
- reassess the patient at least every three months to:
 - ensure the medication is improving function and assess any side effects the patient may be experiencing;
 - determine if the patient may be developing tolerance;
 - confirm there is no evidence the patient may be misusing or diverting the medication. Red flags include:
 - The patient requests early refills, claims to lose the medication or provides excuses for why additional medication is needed.
 - PIN/Netcare review reveals the patient is multi-doctoring to obtain additional medication.
 - An alternate person requests the prescription from the physician when the patient is capable of attending him/herself.
 - Another healthcare professional reports aberrant behaviour, such as a pharmacist reporting the medication is being picked up by individuals other than the patient for no justifiable reason.
- Consider a [gradual taper](#), if clinically appropriate.

For primary prescribers, it is never appropriate to abandon a patient on long-term benzodiazepines, abruptly cut off or threaten to cut off the patient’s medication.

A patient whose benzodiazepine medication is abruptly discontinued or rapidly tapered is at considerable risk.

Resources

- [Prescriber Checklist](#)
- [CPSA Physician Prescribing Practices](#)

Assessing Addiction Risk

- [The Drug Abuse Screening Test \(DAST\)](#)
- [Opioid Risk Tool](#)
- [CAGE Questionnaire](#)

Benzodiazepine Prescribing

Clinical Guidelines

- [Canadian clinical practice guidelines for the management of anxiety, post-traumatic stress and obsessive compulsive disorders](#)
- [TOP Adult Insomnia Summary](#) (for access to the full guidelines, visit the [TOP website](#))
- [Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium \(American Geriatrics Society\)](#)

Training Resources

- [Hone your skills: Are you an effective de-prescriber?](#)
- [Benzodiazepine Use in Older Adults: Dangers, Management, and Alternative Therapies](#)

Summary Toolkits

- [Clinical Toolkit: Use and Taper](#)
- [Choosing Wisely Canada Implementation Toolkit: Less Sedatives for Your Older Relatives](#)

Practice Supports

- [CBT-I Electronic Resources Patient Hand-Out](#)
- [Benzodiazepine Discontinuation Letter Template](#)
- [EMPOWER Benzodiazepine De-Prescribing Brochure](#)

Opioid Prescribing and Pain Management

CADTH Evidence Bundles

- [Pain treatment, including non-pharmacological](#)
- [Opioids](#)



Clinical Guidelines

- [Canadian Guideline for Opioids for Chronic Non-Cancer Pain \(2017\) – full guideline](#)
 - [Poster summary \(English\)](#)
 - [Poster summary \(French\)](#)
- [CDC Guidelines for Prescribing Opioids for Chronic Pain \(U.S.\) – full guideline](#)
 - [Fact sheet](#)
 - [Summary of recommendations](#)

Summary Toolkits

- [Opioid prescribing for chronic non-cancer pain: suggestions summary \(CMPA\)](#)
- [Safer Decisions Save Lives: Key Opioid Prescribing Messages for Community Practitioners \(ISMP\)](#)
- [Checklist for Prescribing Opioids for Chronic Pain \(CDC\)](#)
- [Tapering Opioids for Chronic Pain \(CDC\)](#)
- [Non-opioid Treatments for Chronic Pain \(CDC\)](#)
- [Clinical Toolkit: Urine Drug Screening](#)
- [Clinical Toolkit: Meperidine \(Demerol®\): A Relic Misfit for Chronic Pain](#)

Practice Supports

- [Opioid Manager](#) (for availability in EMR platforms [click here](#))
[How to use the Opioid Manager](#) (McMaster University)
- [Opioid Medication Treatment Agreement Template](#)
- [My Opioid Manager Book \(for patients\) by Dr. Furlan and Amy Robidas](#)
- [Opioid Manager for Prescribers \(iTunes\)](#)
- [Opioid Tool for Prescribers \(iTunes\)](#)
- [Opioid Overdose Prevention for Patients and Caregivers \(iTunes\)](#)
- [Opioid Pain Medicines- Information for Patients and Families \(ISMP\)](#)
- [Video Resources for Patient Education – click ‘Pain’ tab \(My Health Alberta\)](#)

Training Resources

- [Pathways to Safer Opioid Use Module \(US\)](#)
- [Take Home Naloxone Program \(Alberta Health Services\)](#)
- [Opioid Analgesics: Risky Drugs, Not Risky Patients](#)
- [Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain](#)
- [Pharmacotherapy of Chronic Pain: A review](#)



Opioid Dependence Treatment

- [CAMH Opioid Dependence Treatment Core Course \(Alberta Version\)](#)
- [Tapering Opioids for Chronic Pain \(CDC\)](#)
- [Non-opioid Treatments for Chronic Pain \(CDC\)](#)
- [Methadone Program](#)
- [Buprenorphine Prescribing](#)
- [Opioid Dependence Treatment Clinics in Alberta](#)



Appendix A: General Medications List

Standard of Practice: *Prescribing: Drugs with Potential for Misuse or Diversion*

Any medication with a perceived potential for misuse or diversion falls within the scope of this standard, which includes but is not limited to opioids, benzodiazepines, sedatives and stimulants.

Use this list as a general guide:

- Alfentanil
- Amphetamines
- Benzodiazepines
- Buprenorphine
- Butalbital
- Butorphanol
- Cannabidiol
- Cocaine
- Codeine
- Dextro-amphetamine – immediate release preparation
- Dextropropoxyphene
- Fentanyl
- Hydrocodone
- Hydromorphone
- Ketamine
- Marijuana
- Meperidine
- Methadone
- Methylphenidate
- Morphine
- Nabilone
- Nalbuphine
- Normethadone
- Oxycodone
- Oxymorphone
- Pentazocine
- Sodium Oxybate
- Sufentanil
- Tapentadol
- Testosterone
- Tetrahydrocannabinol
- Tramadol
- Zopiclone
- Zolpidem
- Zaleplon



Appendix B: Prescriber Checklist

Use this checklist when prescribing drugs with potential for misuse or diversion to ensure all precautions and requirements have been met.

All prescriptions:

- Documented rationale to justify prescribing – occurs at every assessment/reassessment

During initial assessment, including accepting transfer of care from another healthcare provider:

- Discussed other pharmacological and non-pharmacological options with patient
- Discussed common and potentially serious side-effects of the medication with patient
- Discussed probability that the medication will improve the patient's health
- Discussed probability that the medication will improve the patient's function

When issuing a prescription, at initiation or at minimum at three month intervals for any of the applicable medications, including opioids:

- Reviewed patient medication history from Pharmaceutical Information Network (PIN) /Netcare or alternative independent source (e.g., Triplicate Prescription Program, a pharmacist)
- PIN/Netcare/alternate source not accessible, prescribed minimum amount of medication for interim purpose

When prescribing any of the included medications long-term:

- Patient medication history reviewed periodically, at minimum every three months

When prescribing opioids for long-term therapy for chronic pain (except for active cancer, palliative and end-of-life care):

- Established goals for pain and function
- Measured and documented goals for pain and function initially AND at each reassessment
- Evaluated and documented risk factors for opioid-related harms
- Incorporated strategies to mitigate the risks (e.g., treatment agreement)
- Prescribed lowest effective dose and dose does not exceed CPSA Council-endorsed opioid prescribing guidelines



- If prescribed dose exceeds CPSA Council-endorsed opioid prescribing guidelines, documented additional information with specific justification
- Reassessed Long-term Opioid Therapy (LTOT) by measuring against goals to support need for continuation of therapy within four weeks of initiating LTOT and then at least every three months
- Documented all reassessments of measured benefit in the comparison to risks from continued therapy
- LTOT continued only as measurable clinical improvement in function and pain surpass the risks of continued opioid therapy
- LTOT no longer delivering measurable clinical improvement in function and pain relative to the risks of continued opioid therapy; LTOT discontinued or this prescribing is part of a LTOT discontinuation plan