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Nevada State Board of Pharmacy News

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Board Members

NPI Number and Veterinarians

It has been reported to the Nevada State Board of Pharmacy that some pharmacies are refusing to fill prescriptions written by a veterinarian simply because the veterinarian has no National Provider Identifier (NPI) number. Please be aware that a veterinarian is **not** required to obtain an NPI number. The NPI number applies only to health care providers covered under Health Insurance Portability and Accountability Act who bill Medicare. Obviously, veterinarians are not billing Medicare!

Call for Bowl of Hygeia Award Nominations

The Bowl of Hygeia has been associated directly with pharmacy since 1796 and was adopted in 1964 by American Pharmacists Association as their symbol to represent the profession of pharmacy. Additionally, in 1958, the A.H. Robbins Company established the Bowl of Hygeia Award to recognize and encourage pharmacists to take active roles in their respective communities. The award focuses on community service and is presented annually to one recipient from each state in the United States, the District of Columbia, Puerto Rico, and the 10 provinces of Canada.

Please take the time to nominate that special deserving pharmacist who you feel fits the criteria. The Bowl of Hygeia is a special award, deserving a special pharmacist, of which there are many in Nevada. Contact Larry Pinson, executive secretary of the Board of Pharmacy, at lpinson@pharmacy.nv.gov to make a nomination.

Reminder

If a practitioner's Drug Enforcement Administration (DEA) number is missing on a controlled substance prescription, the pharmacist may add it to the prescription, provided he or she initials that entry. The pharmacist may not simply write "R/A" (readily available) and initial near the missing DEA number as he or she can initial near a missing address of either the patient or the practitioner. (See NAC 453.440(3).)

Update on Buprenorphine Drug Products

Currently, there are four different buprenorphine drug delivery systems available in the US. However, unlike most other groups of drug products that contain the same drug substance, there are significant differences in the indications for these individual products and, based on federal statute and regulation, restrictions on who can lawfully prescribe some of them for certain indications. States may also have further restrictions on which health care professionals can prescribe these various products. This article will clarify the similarities and differences among these products.

The buprenorphine drug products that are currently approved for clinical use by Food and Drug Administration (FDA), along with their corresponding indications and initial approval dates, are listed below. They are all classified by DEA in Schedule III (CIII) under the federal Controlled Substances Act.

Formulation Type	Brand (Proprietary) Name	FDA-Approved Indication	Approval Date
Parenteral	Buprenex®, and generics	Relief of moderate to severe pain	December 29, 1981
Sublingual Tablets	Suboxone®, Subutex®, and generics	Treatment of opioid dependence	October 8, 2002
Sublingual Film	Suboxone	Maintenance treatment of opioid dependence	August 30, 2010
Transdermal Delivery System	Butrans®	Management of moderate to severe chronic pain in patients requiring a continuous, around-the-clock opioid analgesic for an extended period of time	June 30, 2010

The Drug Addiction Treatment Act of 2000 (DATA), codified at 21 USC 823 (g), limits the use of certain buprenorphine-containing drug products for the **maintenance or detoxification** treatment of opioid dependence (ie, opioid addiction) to **physicians** who (a) meet certain qualifying requirements and (b) have notified the Secretary of the Department of Health and Human Services (HHS)

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of their intent to prescribe the products for the management of opioid dependence. HHS processes the notification and contacts DEA. Once the waiver is approved, HHS notifies the physician that he or she has a waiver under DATA and informs him or her of their modified DEA registration number (the so-called "X" number). At present, the only products that meet the criteria in DATA are the sublingual tablets and film (rows 2 and 3 in the table). It is important to note that, for the prescription of these sublingual products, the federal Substance Abuse and Mental Health Services Administration interprets the word **physicians** literally, precluding the prescription of these products by any other type of health care professional **for the management of opioid dependence.** The federal law and regulations do not address the off-label use of these products (eg, prescribing sublingual tablets for the management of pain).

The other buprenorphine products (injectable and transdermal formulations) are approved for analgesic use **only** and are **not** approved by FDA for maintenance or treatment of opioid dependence, so the provisions of DATA **do not affect their legal status or use.** Thus, a physician who does not have a DATA waiver, or a non-physician health care professional that has both federal and state authority to prescribe CIII products, can prescribe either of these analgesic formulations containing buprenorphine.

In promulgating policies and guidances, it is important for policy makers to be cognizant of the differences in indications, formulations, and legal framework related to these products to avoid confusion among licensees and to promote optimal care of the public. References are available upon request to the Board.

Collaborative Initiative to Reduce Adverse Drug Events

Medications offer great benefits to patients, but they come with great risks when not administered or managed properly. Adverse drug events (ADEs) resulting from medications are the most common type of health care-associated adverse events, and as a result, a major source of potentially preventable patient harm. It is estimated that as many as 50% of injuries associated with medication use could be prevented.

HealthInsight, the Medicare Quality Improvement Organization for Nevada, is recruiting community teams to implement evidence-based practices for medication therapy management and medication reconciliation, with the goal of reducing or preventing patient harm caused by ADEs. Interventions will focus on patient-centered care models (as the patient is the one constant) and address the many variables along the care continuum, including multiple prescribers, changes in focus of care, and the care setting. The initiative's foundation is the **Patient Safety and Clinical Pharmacy Services Collaborative** (PSPC) and incorporates intervention strategies to improve clinical outcomes for an identified patient population of focus.

The **patient group** may be high-risk Medicare, Medicare Advantage, and/or dual-eligible patients age 65 or older. High risk patients are those that:

- Have two or more physicians
- Have five or more chronic conditions **or** eight or more medications
- Is prescribed one of the following:
  - Anticoagulant warfarin on a regular basis
    - At least weekly and for three months or more **and/or**
  - Short-acting or long-acting antipsychotics **and/or**
  - Hypoglycemic medication for diabetes

For more information or to join the collaborative effort, please contact:

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