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WYOMING STATE BOARD OF PHARMACY

newsletter to promote pharmacy and drug law compliance

Summary of the Revisions to the Wyoming Pharmacy Act and Wyoming Controlled Substances Act Rules and Regulations

Below is a summary of the rules revisions that have been signed and approved by Governor Mark Gordon in 2021. The updated chapters are posted on the Wyoming State Board of Pharmacy's website and can also be found on the Wyoming Administrative Rules website by visiting *rules.wyo.gov*. Pharmacists, pharmacy interns, pharmacy technicians, and technicians-in-training should review the revised chapters and familiarize themselves with the changes.

Wyoming Pharmacy Act Rules and Regulations	
Chapter 16: Immunization Regulations	• Vaccines for the coronavirus disease 2019 (COVID-19) were added to the vaccines that are allowed to be prescribed and administered to healthy adults or healthy minors or that may be administered by a prescription of a physician to a high-risk adult or high-risk minor. • The incorporation by reference was updated to include the current 2021 Centers for Disease Control and Prevention-recommended vaccine schedules. • The definition for "private space" and the requirement for individuals receiving vaccinations while seated in a chair with back support was removed. • The basic life-support requirement was amended to basic CPR.
Chapter 17: Sterile Compounding	• Language was created to modernize the sterile compounding requirements in accordance with the current standard of practice. • The changes were made to this chapter because the Board had previously incorporated the September 2018 version of the United States Pharmacopeia (USP) General Chapter <797>, which has since been remanded. The revisions of this chapter outline the rules for sterile compounding rather than incorporating a specific version of USP Chapter <797>.

Wyoming Controlled Substances Act Rules and Regulations Changes	
Chapter 10: Issuing and Dispensing Prescriptions for Controlled Substances	• Updated language to exempt controlled substance (CS) prescriptions that are to be dispensed from a pharmacy within a federal jurisdiction from the electronic prescribing requirement.

Pursuant to Wyoming Statute 35-7-1030, CS are now required to be electronically prescribed. The requirements for electronic prescribing systems and exemptions to the electronic prescribing requirement can be found in the Wyoming Controlled Substances Act Rules Chapter 10. The exemption for when a prescriber's electronic prescribing system is not functioning is not intended to mean that practitioners do not need an electronic prescribing system. The compliance officers are inspecting non-electronic CS prescriptions for compliance with the e-prescribing mandate.

Methadone Regulation

By Andrew Trautman, PharmD Candidate

Methadone is one of three medications, along with buprenorphine and naltrexone, approved by Food and Drug Administration to treat opioid use disorder (OUD). Methadone, also approved for pain management, is the most studied of the three medications and is classified as a Schedule II CS. Methadone is a long-acting mu-opioid receptor full agonist, and its principal therapeutic uses are for analgesia and detoxification or maintenance in opioid addiction. By law, methadone can only be dispensed for OUD at certified opioid treatment programs (OTPs), which are regulated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Drug Enforcement Administration (DEA). Patients in these programs must undergo behavioral counseling, supervised methadone dosing, and drug screening. Despite being shown to reduce opioid mortality and use, methadone is one of the most regulated drugs in the US. This is in part due to its Schedule II classification and the stigma of OUD therapy.

While methadone can only be dispensed at SAMHSA-certified OTPs for OUD, there have been some initiatives to help underserved areas get access to the medication. OTPs can create medication units, which are separate entities that can dispense methadone. These medication units can be in primary care settings, community pharmacies, and hospitals. The unit must have a separate and unique DEA registration from the parent OTP. All SAMHSA-required services, such as behavioral counseling and drug tests, must be done at the parent OTP. These medication units help patients in rural areas who are unable to travel great distances for clinics. OTP mobile vans are another strategy to help with this distribution of methadone. The mobile vans work like methadone clinics, dispensing the medication while also providing a space to counsel and perform drug screening. These vans also serve those areas in need, as they can travel to areas that do not have a clinic but need OUD therapy.

There are some scenarios in which methadone can be administered outside of an OTP. A prescriber who is not certified by SAMHSA may administer, not dispense, methadone for a patient suffering from opioid withdrawal if there are plans for the patient to be in an OTP. This rule is referred to as the "three-day rule" since the treatment can only be for a 72-hour period and the doses of methadone can be only

for one day. Hospital providers can also dispense and administer methadone to "detoxify" patients. There is no mention of a limit on the number of days that a hospital provider can dispense methadone.

Recently, methadone regulations have seen progress in some states. Kentucky has increased its total number of medication units, while Ohio has added more to rural areas, jails, and prisons. Indiana increased the state cap on the total number of OTPs, growing from 14 to 18, with plans to add nine more in the future. DEA recently announced that OTPs can create mobile methadone vans without having to obtain a separate DEA registration for each van. There have been no new mobile vans since 2007. This policy is a step in the right direction to hopefully create more. Currently, there are no methadone clinics in Wyoming, but considering the recent progress in methadone regulations, it will be interesting to see if any are created and what kind of role a pharmacist can have in the level of care.

Polypharmacy and Deprescribing

By Rodney Young, PharmD Candidate

Polypharmacy is usually defined as patients taking five or more medications, including over-the-counter (OTC) medications. A study in *JAMA Internal Medicine* found that 36% of community-dwelling adults, ages 62 to 85, take five or more medications. With the addition of each medication, there is an increased risk for adverse drug effects to occur (drug-drug interactions, drug-disease interactions, pharmacokinetic and pharmacodynamic interactions, additive side effects, and decreased medication adherence). Polypharmacy also increases the risk of medication errors, by both providers and pharmacists. The patients who are most at risk for adverse effects are those over 62 years old with comorbidities, those who have multiple prescribers, those with mental health conditions, adults in long-term care facilities, and those who self-medicate with OTC medications.

There can be many factors that lead to polypharmacy. A prescribing cascade can occur when patients are prescribed medications to treat adverse effects of another medication. Medications may no longer be effective, or necessary, for the condition they were originally prescribed for. If a patient sees multiple providers where there is a lack of adequate communication or poor transition of care, inappropriate prescribing can result. Polypharmacy can also occur when medical records are not updated and discontinued medications are automatically refilled. Patients who use multiple pharmacies to fill prescriptions could also add to polypharmacy by hindering the ability for any pharmacy to develop a complete list of all medications prescribed.

When an issue with polypharmacy has been identified, deprescribing should be considered to help resolve the problem. Deprescribing is an attempt to find the optimal medication regimen that maximizes benefits and minimizes potential harm. This process may be better suited to pharmacists working in clinical settings, but there is also potential for retail pharmacists to have a role. A retail pharmacist may have the most complete picture of all the medications that a patient is prescribed, provided that the patient only uses one pharmacy. Retail pharmacists may also find opportunities for deprescribing when they conduct prospective and retrospective drug use reviews.

When contemplating deprescribing, some medication classes have a higher risk-benefit ratio in older adults and should be considered first: anticholinergics, benzodiazepines, antipsychotics, opioids,

proton pump inhibitors, non-steroidal anti-inflammatory drugs, aspirin, antihyperglycemics, and statins. When deprescribing, some barriers may need to be overcome. Often, patients are hesitant to stop a medication that a doctor had prescribed because patients may fear that the condition it treats will worsen upon discontinuation. The patient may also be concerned with adverse withdrawal effects. Practitioners may also be reluctant to go against the treatment of another provider.

Deprescribing is a potentially scary journey into uncharted waters for many patients, and they must have utmost confidence in their guide. Communication, trust, and mutually agreed-upon goals will be critical components to success throughout the process and ensuring patient buy-in. The following steps can help guide the deprescribing process:

1. Determine all the medications that a patient is taking, including OTC medications.
2. Identify medications that are harmful, unnecessary, or inappropriate for the patient (eg, lack of indication, not effective, incorrect doses, duration beyond necessary, negative effects, duplicate medications, no benefits available within the patient's expected lifespan).
3. Prioritize medications for discontinuation and develop a plan. Seek to remove those with the most potential for harm and the least benefit. Use evidence-based guidelines and algorithms when possible.
4. Discuss the plan with the patient. Ensure that they understand why each medication was considered for discontinuation. Let them know what to expect and watch for.
5. Implement the discontinuation plan. Start with medications that the patient is willing to discontinue and are easy to discontinue.
6. Follow up with the patient, monitor, and adjust the plan as necessary. Deprescribing may change the pharmacokinetics and pharmacodynamics of the remaining medications; this may require adjusting the dose of the remaining medications.

There are many guidelines, criteria, websites, and apps that can assist a clinician in the deprescribing process. Many are free, while others require subscriptions. Some examples are listed below.

- **The Beers List:** Useful for identifying medications that have the highest risk for geriatric patients. It categorizes medications that should be avoided, used with caution, and that are hazardous to elderly patients. It is also useful in providing alternative medications that you can try.
- ***Deprescribing.org*:** Provides deprescribing guidelines and algorithms, deprescribing information and aids for patients, and links to other free deprescribing resources.
- ***MedStopper.com*:** Allows you to enter a list of drugs for a patient and receive recommendations regarding which medications might be discontinued or switched.
- **STOPP/START Criteria:** Screening criteria for clinicians, it is especially useful in treating older patients. It can help identify potentially inappropriate (STOPP) and appropriate (START) medications.

Enhancing Clinical Practice Through Team-Based Care

Throughout the pandemic, many pharmacists have seen firsthand how patient care has been impacted. These impacts have included patients not being able to see their primary care provider because of COVID-19 restrictions, health care system overload resulting in delay of medical care, and a lack of technology for some patients to connect virtually with their health care providers. An area where pharmacists may make a difference is collaborative practice.

The Wyoming Pharmacy Act Rules allow for collaborative practice agreements (CPAs) between one or more pharmacists and one or more practitioners licensed in Wyoming to work in conjunction to achieve optimal medication use and desired patient outcomes. The Wyoming Center on Aging (WyCOA) and the University of Wyoming School of Pharmacy have resources on CPAs, including an informational video that can be found here. There are also education modules on medication therapy management, chronic care management, co-visits, annual wellness visits, and transitional care management. Each of these modules is eligible for Accreditation Council for Pharmacy Education-accredited continuing pharmacy education credit.

Pharmacists can bill for collaborative practice services. There are three ways for potential billing and sustainability of these types of services. This can be done through "incident to" billing as auxiliary personnel, maximizing the evaluation and management coding per the revised Centers for Medicare & Medicaid Services guidelines, and as part of chronic care management.

WyCOA believes that pharmacists play a vital role in patient care and wants to assist in educating pharmacists, providers, and administrators on the importance of CPAs in expanding the services available to Wyoming residents. WyCOA may be contacted via email at healthierwyo@uwyo.edu.

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