
FAQ

Fentanyl Patch Return Program

What is the Fentanyl Patch Return Program?

A Fentanyl Patch Return Program is a collaboration between physicians, pharmacists, and patients to promote the safe, effective and responsible use of fentanyl patches. In general, it applies a 'one in, one out' model, where clients are asked to return any patches previously dispensed to them back to the pharmacy before they are able to receive more.

What are the physicians being asked to write on the script?

The script should direct the pharmacist to collect used or unused patches before dispensing the next set of patches. See attached sample prescription for an example.

When the physician writes this on the script, are all pharmacists forced to comply?

A prescription is essentially a "permission" for a particular product to be dispensed for a patient. When a prescriber writes specific instructions for the pharmacist, such as those provided in the example, it is certainly expected that the pharmacist will follow or adhere to those specific instructions if it is in the best interest of the patient to do so. A pharmacist is expected to use their professional judgment whenever they are involved in patient care activities.

When a pharmacist chooses to not follow the instructions of the prescriber, that decision should be discussed with the patient, the decision should be documented, and the prescriber should be notified.

Will the OCP support me on this?

Ontario College of Pharmacists (OCP) is in favour of professional activities that support patient care, and which protect the public interest. Because the Fentanyl Patch Return Program is designed to support the safe disposal of a potentially dangerous medication after its therapeutic use has finished, we expect that OCP will support this program and the pharmacists who participate.

OCP does not currently have a "Best Practice" recommendation on this matter, but there are parallels to some of the policies and guidelines that pharmacies must adhere to when dispensing methadone.

OCP is also in favour of three-way Narcotic Contracts between the physician, patient, and pharmacy, and encourages physicians to incorporate a Fentanyl Patch Return Program clause in their Narcotic Contracts.

Why don't the physicians just not issue any refills and have the patches returned to them before issuing next script? Then they become aware of any concerns and the pharmacist is not "policing".

Physicians generally do not have a mechanism for the safe disposal of hazardous wastes such as medications. Pharmacists have a system for drug disposal available to them at no charge through the Ontario government. In addition, pharmacists are in a unique position as they see patients more often and are involved in handling new and discarded medications on a daily basis.

This initiative is intended to be a shared responsibility between the physicians and the pharmacists. The physicians are being asked to discuss this mechanism with their patients and add it to their Narcotics Contracts.

Have we considered patient education regarding disposal and handing out disposal containers instead?

A cornerstone of the Fentanyl Patch Return Program will be the need for patients to be educated about the dangers of used patches and the need for their safe disposal at pharmacies.

A home disposal container for Fentanyl Patches could potentially be viewed as more attractive to drug seekers. This would not adequately deal with the issue of diversion, and may facilitate crime in the form of home invasions.

How do we handle a situation where a patient brings back 8 out of 10 patches?

It is suggested that if it happens once that they be reminded of the need to return the meds; and if it happens again, they are to receive one per dosing period until the doctor can be reached, and they must see their physician to decide if it is appropriate to continue the script as it is.

For first scripts there will be only 9 out of 10 patches returned.

Yes, that is expected to be a one-time occurrence and should be documented.

How should the used patches be stored?

It is recommended that patients stick the used patches onto a sheet of paper, in a non-overlapping sequential order, so that each patch can easily be recognized and accounted for. These sheets will be made available through public health. An example of a sheet that may be used for this purpose can also be obtained at <http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Patch-Exchange-Disposal-Tool.pdf>

Patients should store the sheet with used patches out of sight and out of the reach of children and/or pets. It should be treated with the same care and concern as other medications.

Once returned to the pharmacies, the returned sheets with used patches should be placed into the pharmacy's drug disposal bin to be removed and destroyed on a regular basis.

How do we handle a vacation supply (larger quantity than patient has returns for)?

The patient must return the quantity of patches that they received in their last order. 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 next prescription is for a smaller quantity than the current prescription. It will be important to document the changes for appropriate record keeping.

What if there is a new Rx to our pharmacy but has been filled elsewhere locally?

If the script is ongoing and changing from another pharmacy they should bring in the old patches to receive the new ones. This will avoid changing pharmacies to divert medications.

What if the patient says s/he has returned her/his patches to the doctor's office and you can't reach office to verify?

As indicated in above, physicians are not equipped to handle the return and disposal of used patches. Thus, this is not likely to happen. On the off-chance that a patient does give their patches to their physician, the physician has been asked to document this fact on the prescription.

As in all activities, pharmacists are reminded that they are required to use their discretion and professional judgment in patient care activities. In an example such as this, the pharmacist may choose to dispense one patch to the patient until the prescription and location of the used patches can be verified with the prescriber.

How do I handle the delivery situation?

Pharmacy delivery personnel are considered agents of the pharmacy, and should be advised of the need to collect used patches from patients. In a similar way in which they collect money, drug cards, expired medications, and other items such as signatures under the ONMMS, they can also be entrusted to collect and return used patches to the pharmacy.

As a best practice when delivering a Fentanyl Patch prescription to a patient, it would be advisable for both the patient and delivery personnel to sign the ONMMS delivery record to indicate that they picked up used patches from the patient.

Who do I notify if I feel there is an issue with diversion?

The medication should not be dispensed and the prescribing doctor notified.

What do I do if I encounter what I suspect to be a counterfeit patch?

Advise the patient that it is an indictable offense to unlawfully obtain narcotics and that they must bring in all the used patches before you can dispense more.