*****I made my comments below at certain places denoted with three stars at the beginning. Each starting with *****

Prescribing Drugs

Policy Number:7-16
Policy Category: Drug/Prescribing
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Introduction

Principles

Purpose and Scope

Definitions

Policy

Physicians must comply with the expectations set out in this policy when prescribing drugs or providing drug samples.

Please use the links below for a detailed description of the expectations.

2. SPECIFIC ISSUES IN PRESCRIBING

> Refills

> Drug Samples

> Narcotics and Controlled Substances

> Drugs that have not been Approved for Use in Canada (‘Unapproved Drugs’)

GUIDELINES

> Preventing Medication Errors

> Narcotics and Controlled Substances

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1. General Expectations

Before Prescribing

Physician-Patient Relationship

Assessment

Exceptions

The circumstances in which physicians are permitted to prescribe without a prior assessment of the patient can include:

1. Prescribing for the sexual partner of a patient with a sexually transmitted infection (STI) who, in the physician’s determination, would not otherwise receive treatment and where there is a risk of further transmission of the STI;
2. Prescribing prophylaxis (e.g., oseltamivir) as part of public health programs operated under the authority of a Medical Officer of Health; and
3. Prescribing post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne pathogen.

*** #1) prescribing for the sexual partner of a patient is a problem. I understand the intent. Try to protect the patient. However, Today, there is no reason that this assessment of the sexual partner cannot take place even if by phone/data call/video call/internet, even if they are out of jurisdiction or out of country. Not making these attempts falls below the standard of care. It is much more common than we realize in medicine, namely how often it becomes necessary to treat the partner or member of a patients social circle, etc. How are we implying consent of any kind in discussing the partners health and treatment if they never even participated, nor interacted at all ever? Second hand informed consent?

Informed Consent

As with the usual requirements for informed consent when considering any treatment, 15 physicians are required to advise the patient about the material risks16 and benefits of the drug being prescribed, including the drug's effects and interactions, material side effects, contraindications, precautions, and any other information pertinent to the use of the drug.

When Prescribing

Content of Prescriptions

Physicians must include the following information on a prescription:

- Name of patient;
- Name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for use of the drug;
- Full date (day, month and year);
- Refill instructions, if any;
- Printed name and signature of prescriber (if outside of an institution, include address and telephone number of location where medical records are kept);
- CPSO registration number; 17 and
- Any additional information required by law.

If the prescription is for a monitored drug, 18physicians must also include an identifying number for the patient (e.g., health card number) 19 and indicate the type of identifying number it is (e.g., health card), unless certain conditions set out in regulation are met.20

If the prescription is for a fentanyl patch, physicians must include the following additional information on the prescription20a:

- The name and address of the pharmacy where the prescription will be filled;20b
- A notation that it is the patient's first prescription for fentanyl patches when:

1. The physician has not previously prescribed fentanyl patches to that patient; and
2. The physician is reasonably satisfied20c that the patient has not previously obtained a prescription for a fentanyl patch from another prescriber

*** Should this be mandatory for all Narcotics and controlled substances? Maybe it is time we consider placing the patients chosen pharmacy on all prescriptions?

It is recommended that physicians consider, on a case-by-case basis, 21 whether it is appropriate to include the following information on the prescription:

- Address and/or date of birth of patient
- Indication for use, if prescribed p.r.n.
- "No substitutions", if applicable and clinically appropriate 22, 23
- "Do not adapt", "do not extend" or "do not refill", when prudent or advisable 24
- The patient's weight and/or age (e.g., where the patient is a child and this information would affect dosage)

***** Age/DOB is essential on all prescriptions**

Clarity

a. Verbal Prescriptions

Medication safety literature highlights that the use of verbal prescriptions is error-prone. Physicians must have protocols in place to ensure verbal prescriptions are communicated in a clear manner. 25

b. Handwritten or Electronic Prescriptions

To improve legibility, among other things, the College recommends that physicians take advantage of technology, for example, by generating prescriptions via their Electronic Medical Record (EMR) system.

When generating prescriptions, physicians must pay particular attention to the use of abbreviations, symbols and dose designations, and must avoid using the abbreviations, symbols, and dose designations that have been associated with serious, even fatal, medication errors. 26 It is recommended that physicians use TALLman lettering 27 for drug names that may look-alike and/or sound-alike. 28

When generating prescriptions electronically, physicians must ensure the proper drug, dose and dosage form are chosen when selecting from a list of drugs and doses.

Authorization

Every prescription must be authorized by a prescriber before it can be filled and dispensed. A prescriber can authorize a prescription verbally, with a signature, or electronically. Regardless of the method of authorization, each prescription must only be authorized once. 29

a. Verbal

A prescription can be authorized by a physician verbally; however, there are some limitations on the use of verbal prescriptions. 30 For example, Section 40(3) of *General*, O. Reg., 58/11, enacted under the *DPRA* states that a drug shall not be dispensed in a pharmacy pursuant to a prescription given verbally unless several conditions have been met, including that the drug is not a narcotic drug. 31

b. Signature

A prescription can be authorized by a physician's signature. The signature must be authentic and unaltered. 32 Electronic signatures may be acceptable if they meet the College of Pharmacists (OCP) *Authenticity of Prescriptions using Unique Identifiers for Prescribers* position statement. For example, the electronic signature must be a unique, clearly identifiable, life-size image. 33 Before physicians begin signing prescriptions electronically, it is recommended that they communicate with the pharmacist regarding the process they are using to sign the prescriptions, to ensure the pharmacists' requirements are being met.

c. Electronic

Electronic prescriptions can only be authorized by an authorized prescriber. 34 There must be a mechanism that prevents duplicate prescription authorization and the prescription authorization mechanism 35 must be:

- Secure; 36 and
- Acceptable for the purposes of authentication to pharmacists.

***** An image of the authorized prescription or copy should be retained in the medical record.**

***This way regardless of whether the authorized prescription is transmitted by the EMR or printed and handed to the patient and it can be checked against the copy should a future need arise or dispute over any differences, once it arrives to the pharmacy or in the event that it does not arrive. Tampering of prescriptions is not uncommon.

*** An authorized prescription indicating that it was dispensed as a sample is another way to track what was dispensed to the patient. It also serves to communicate to the pharmacy of the patient so that they can be up-to-date on all the medications the patient maybe taking. Should this be mandatory? Including transmission to the pharmacy?

After Prescribing

Transmitting a Prescription

In an ePrescribing context, authorization and transmission of a prescription are often combined. However, regardless of the method of transmission (e.g., paper, verbal, fax, 38 digitized image files 39 or electronic), physicians must comply with the following requirements:

1. All prescriptions transmitted must originate with the prescriber; 40
2. The process of transmitting prescriptions must maintain patient confidentiality;
3. Transmission of the prescription must employ reasonable security measures (e.g., password protection, encryption, etc.). 41 This includes transmission to or from the EMR (i.e., from a stand-alone application to the EMR or from the EMR to the dispenser); and
4. Patient choice must be protected; that is, the patient must have a choice of pharmacy where the prescription is to be filled. 42

Physicians must respond in a timely and professional manner when contacted by a pharmacist 43 or other health-care provider to verify a prescription or respond to a request for information about the drug prescribed.

Notifying pharmacies of a fentanyl prescription

Where a physician prescribes fentanyl patches, physicians must notify the pharmacy that will fill each prescription directly, either by telephone or by faxing a copy of the prescription.43a

*** The problems with fentanyl also apply to many other medications. Is it time to consider similar prescribing practices for all Narcotics and controlled substances or even all medications? Patients can still exercise their

pharmacy choices by indicating which pharmacy they would like the prescription transmitted to. This strengthens the circle of care around the patient because both the physician and pharmacy will be better connected.

Documentation

In addition to complying with the general requirements for medical records, 44 physicians must specifically document the following information regarding the drugs they prescribe in a patient's medical record:

- The date the drug is prescribed;
- The type of prescription (verbal, handwritten, electronic);
- The name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for use of the drug;
- The fact that the drug's material risks, including material side effects, contraindications or precautions were discussed with the patient; 45
- Refill information; and
- Other relevant information (e.g., drug cannot be substituted; prescription cannot be adapted, extended or refilled, as applicable).

The College recommends that entries be recorded as soon as possible after the encounter. This is important to ensure safe delivery of care, especially in a shared care environment. 46

The documentation requirements set out above apply to physicians even if they are verbally prescribing, refilling prescriptions, or providing a patient with a drug sample.

*** Is this adequate today? Or is it time that we make it mandatory for a full copy or image of the prescription? How else can we reliably track errors or tampering when they happen?

a. Audit

Physicians who have an EMR with ePrescribing capabilities must ensure that their system is able to track all electronic prescriptions, who authorized them, whether they were printed or authorized and transmitted, where they were sent and whether/by whom they were modified and when. The system must also be able to identify what additions or edits were made to the prescription record over time. 47

*** Very nice idea, but the reality is that even the two best EMR's for private practice do not allow for this in all circumstances. They do not allow for the proper differentiation so physicians are left choosing to be a physician or an operator of the EMR. Even hospital EMR's struggle with this standard. This is great but what are we going to do about the reality that the regulations have now surpassed the EMR's capability. Just to be clear, the EMR companies will tell you that

it can be done and if you do not that you are using the EMR "wrong". Really, is that what we should be telling physicians? Use it this way only? Even if that means it slows you down and you cannot get to as many patients? Even hospitals still have paper prescriptions. Some can print them. I don't know any transmitting them electronically (by fax yes- but that is a printed copy) yet, but I have not investigated.

Physicians must also ensure that their system is able to generate reports that contain the results of queried information (e.g., list of prescriptions issued to a particular patient, prescriptions issued by the prescriber, or prescriptions written for a particular drug, etc).

*** Many can do this but how easy is it? You can get the information but it will be in a different format than the original. This may be another regulation ahead of ability. My hospital can generate a report, but it reads very differently than a prescription insinuating slightly different information.

Monitoring

*** The suggestions help pharmacist in their monitoring too.

Sharing Information

To ensure good patient care is provided, communication between physicians and health-care providers is recommended. If the patient has a primary care provider, it is important for that provider to have all relevant information about his or her patient. This includes information about drugs prescribed for the patient. Unless a patient has expressly withheld or withdrawn consent, health information can be shared within the 'Circle of Care' 48 in accordance with the *Personal Health Information Protection Act, 2004* (*PHIPA*).

*** See suggestion on prescription of samples dispensed

2. Specific Issues in Prescribing

Drug Samples

*** See suggestion on prescription of samples dispensed

Narcotics and Controlled Substances

Before prescribing

When prescribing

Physicians who elect to prescribe narcotics and controlled substances to a patient must be mindful of the potential risks they pose, and take reasonable steps to mitigate those risks, consistent with relevant practice standards, quality standards, and clinical practice guidelines. In particular, these steps must include the following:

1. Ensure that the patient understands the risks associated with the drug being prescribed, including any risk of addiction and overdose.
2. Consider and apply relevant practice standards, quality standards, and clinical practice guidelines to determine a safe and effective dose.58a

i. Physicians are reminded that with respect to the prescribing of opioids for chronic, non-cancer pain, both the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* and the *Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain*strongly recommend against prescribing doses above 90 morphine milligram equivalents (MME)/day.58b

3. Recognize patients who are receiving an unusually high dose, and slowly taper those patients when appropriate, consistent with relevant clinical practice guidelines.58c
4. Recognize and respond to signs of abuse, misuse, and diversion when such signs are present.58d
5. Share information with others in accordance with physicians' legal obligations, including those set out in the *Personal Health Information Protection Act, 2004 (PHIPA)58e*, and any applicable mandatory reporting obligations.58f
6. Institute measures to prevent prescription pad theft or tampering; taking measures to prevent the theft of drugs from their offices.

*** With reference to #5.

***We need to indicate in these guidelines about the balance that exists between maintaining confidentiality of the patient and our duty to protect the public more clearly. This is especially important when a physician learns of diversion and the diversion is related to minors or other vulnerable populations. The way this is worded it appears to place more emphasis on confidentiality than duty. Maybe the specific duties to report should be listed here?

Office Policies and Practices: Setting and Managing Patient Expectations

a. General Policies and Practices

It is recommended that physicians who prescribe narcotics and controlled substances consider implementing office policies and practices regarding the prescribing of these drugs, for example, a policy on the use of treatment agreements. 59 Communicating these office policies and practices to patients can help manage patient expectations and help monitor whether the treatment is being used as prescribed.

b. 'No Narcotics' Prescribing Policy

When physicians are asked by patients to prescribe narcotics or controlled substances, 60 they may feel obligated or pressured to prescribe them. In fact, some physicians have a general 'no narcotics' policy in order to avoid such situations.

Having a blanket 'no narcotics' policy removes the physician's ability to exercise his or her clinical discretion when considering whether or not to prescribe narcotics and controlled substances to a particular patient. Instead of having such a policy, it is advised that physicians use their professional judgment to determine whether prescribing narcotics and controlled substances is appropriate for each patient. Physicians have no obligation to prescribe any drug, including narcotics and controlled substances, if they do not feel it is clinically appropriate.

As such, the College recommends that physicians do not adopt a blanket policy refusing to prescribe narcotics and controlled substances, unless physicians have restrictions preventing them from prescribing narcotics and controlled substances. Prescribing narcotics and controlled substances are part of good clinical care and refusing to prescribe these drugs altogether may lead to inadequate management of some clinical problems and may leave patients seeking treatment from other physicians, putting pressure on others to manage these cases, or otherwise leaving patients without appropriate treatment.

Monitoring Patients: Misuse, Abuse and Double-Doctoring

When prescribing narcotics and controlled substances, physicians must be alert for behaviour which suggests that patients are seeking drugs for diversion purposes, or are misusing or abusing prescription drugs. 61

One of the ways in which patients may access narcotics and controlled substances to misuse or abuse is by double-doctoring. Under the *CDSA*, a person who has received a prescription for a

narcotic shall not seek or receive another prescription or narcotic from a different physician without telling that physician about every prescription or narcotic that he or she has obtained within the previous 30 days. 62

Sharing Information

If physicians suspect or discover that their patient is double-doctoring, or is otherwise misusing or abusing narcotics and controlled substances, they might be unsure as to what to do with that information. Physicians must keep patient health information confidential and private, unless they have consent to share the information or are permitted or required by law to do so.

*** here's another location that the balance between confidentiality and duty to report could be mentioned in greater detail.

The following sections outline the most relevant requirements in *PHIPA* regarding consent, along with the instances in which physicians are permitted by law to disclose information without consent. If physicians are uncertain of their obligations, or whether the sections set out below apply in the circumstances of specific cases, physicians are advised to seek legal advice.

*** Adding protection of the public such as protection of kids here might be useful.

a. Circle of Care

The majority of circumstances addressed in this policy contemplate that physicians will share a patient's personal health information, including prescriptions, with other members of the patient's health-care team for the purpose of providing or assisting in the provision of health care.

Generally speaking, in these situations, physicians can assume they have a patient's implied consent to share personal health information (including information regarding prescriptions) with other members of the patient's health-care team, 63 and they will not need to seek patient consent each time. Physicians cannot, however, assume patient consent if the patient has expressly stated that he or she does not want the information to be shared.

b. Permitted Disclosure

PHIPA contains a number of provisions which permit personal health information to be disclosed without patient consent. The decision to disclose information in these situations is at

the physician's discretion. 64 Physicians must use their professional judgment to determine whether the circumstances of each case satisfy the requirements of the provision and disclosing the information is justified.

PHIPA contains a number of provisions which permit disclosure. These provisions that are most likely to be relevant to prescribing information are described below.

i. Disclosure for authorized investigations or inspections

- This provision enables information to be disclosed in the context of an investigation or inspection, for the purposes of facilitating that investigation.
- The investigation or inspection must be authorized by a warrant, or by an Act of Ontario or an Act of Canada.
- The disclosure must be made to the person who is authorized to do the investigation or inspection. 65 The Canadian Medical Protective Association (CMPA) has provided information regarding double-doctoring and responding to inquiries from law enforcement officials in its article *Responding to Prescription Fraud*. 66

ii. Disclosures related to risks

- This provision allows for information to be disclosed in order to prevent or reduce a risk of harm to others.
- To rely on this provision, health-care providers must believe on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. 67

*** Add detail about kids etc ?

Mandatory Reporting Obligation

Ending the Physician-Patient Relationship

Drugs that have not been Approved for Use in Canada ('Unapproved Drugs')

Physicians must not prescribe drugs that have not been approved for use in Canada, that is, drugs for which Health Canada has not issued a Notice of Compliance (NOC). 69 However, there are two circumstances when access to an unapproved drug can be obtained for patient use. The first is when drugs have been authorized by Health Canada for research purposes as part of a clinical trial. The other is when drugs have been authorized under Health Canada's Special Access Programme. 70

If physicians consider obtaining access to drugs for patients under these circumstances, they must comply with Health Canada's requirements.

*** Not writing prescriptions for out of country drugs and or treatments is seriously problematic. We have to consider Canadians, non-Canadians, residents, non-residents and visitors especially residents of other jurisdictions who may be on treatments that are not health Canada approved. Good examples of this are our American neighbors. Furthermore, patients are becoming more worldly; they are informed of treatments that might be outside of the jurisdiction they reside in. The matter becomes even more complicated if the interaction is not in Canada. What if the prescriber is in Canada and the patient is not? Or Vice versa? These situations apply even if you are not physician on a border town between Canada and the US.

Patients can feel offended if you are not informing them of treatments there are available outside their jurisdiction or their country. Patients feel they have a right to seek treatment regardless of jurisdiction.

Maybe it would be more appropriate to state that a prescriber should identify to patients when a prescription is not health Canada approved similar to notifying patients of off label use of medications?

Guidelines

Preventing Medication Errors

Vulnerable Populations/High-alert Environments

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Patient Involvement

Medication safety literature recognizes that patients represent an untapped resource for reducing the incidence of medication errors. It is recommended that physicians encourage their patients to: question why they are receiving a drug; verify that it is the appropriate drug, dose and route; and, alert the health-care provider involved in prescribing, dispensing, or administering a drug to potential problems, such as allergies or past drug-drug interactions, any new physical symptoms/side effects that occur, or any changes in their clinical status. 76

Physicians are encouraged to be alert to the possibility of an error in the dispensing of a drug when a patient expresses concern that the drug dispensed is different from that previously provided.

If a prescription is generated, authorized and transmitted electronically, the physician may wish to generate a record/receipt of the prescription for the patient. This would accomplish several things:

- Ensure the patient knows what they have been prescribed;
- Give the patient an opportunity to go home and look up the drug; and
- Avoid errors of dosing,

*** Of Note: Printing a copy of the prescription that is electronic will work well if we take the work out of having patients transmitting written prescriptions or otherwise generated prescriptions by having them choose a pharmacy to be written on the prescription and faxing or otherwise transmitting the prescription for them. See risk below and possible solution. Do we really still want patients to take a prescription and do the delivering of it? Surely we can preserve their choice while making the delivery more reliable, secure and maintaining a copy of the prescription for the medical record. Making this mandatory means that providers will have a better connection with the patients pharmacy. See below for more on this topic.

Narcotics and Controlled Substances

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Monitoring Patients

Physicians may wish to keep a narcotics and controlled substances log 84 for each patient. This would help physicians keep track of what was prescribed for each patient, to ensure patients are not over-prescribed narcotics and controlled substances. 85 The use of technology could help in this regard (e.g., EMR).

Preventing Prescription Fraud 86

In issuing prescriptions for narcotics and controlled substances physicians may want to consider taking the following precautions:

- If using a paper prescription pad:
  - Use carbon copies or numbered prescription pads;
  - Write the prescription in words and numbers;
  - Draw lines through unused portions of the prescription; and

*** is it time to consider making it mandatory to keep a copy of the prescription on file? Is it time to consider not releasing a copy of the prescription to the patient? Is it time to consider insisting or making it mandatory to send the prescription by fax or other electronic means to the patient's chosen pharmacy? (Then providing a copy is less likely to be misused). Is it time to consider these changes for all prescriptions Narcotics or otherwise?

- Promote the patient's use of a single dispensing pharmacy of their choice. Include the name of the pharmacy the patient would like to take the prescription to be dispensed, on the prescription.
- Fax (or electronically transmit when available) prescriptions directly to the pharmacy.
- If using fax or electronic transmission of the prescription (when permitted) ensure confidentiality,87 confirm destination, and retain copies.

***Faxing prescriptions directly to the pharmacy was the only way to prevent a patient that was photocopying the prescription to be filled at multiple pharmacies or taking the prescription and filling it out of her jurisdiction. The CPSO should consider making this mandatory for any narcotic prescription. This could even be a consideration for all prescriptions. Putting the pharmacy on the prescription that the patient chooses the prescription to go to when it is to be faxed to can only promote proper care.

Thank you for the opportunity to participate. If you have any further questions on this feedback, please let me know.