The College of Physicians and Surgeons of Ontario

Prescribing Drugs – Draft Policy

Policies of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant legislation and case law, they will be used by the College and its Committees when considering physician practice or conduct.

Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When 'advised' is used, it indicates that physicians can use reasonable discretion when applying this expectation to practice.

Policy

1. Physicians **must** comply with the requirements for prescribing that are set out in this policy, as well those contained in any other relevant College policies[1] and legislation[2].

Before Prescribing

2. Physicians **must** only prescribe a drug if they have the necessary knowledge, skill, and judgment to do so safely and effectively.[3]

3. Before prescribing a drug, physicians **must**:

   a) undertake an appropriate clinical assessment of the patient (limited exceptions are set out in provisions 4 and 5 of this policy);[4]
   b) make a diagnosis or differential diagnosis and/or have a clinical indication based on the clinical assessment and any other relevant information;

[1] Other relevant policies include (among others): Cannabis for Medical Purposes, Confidentiality of Personal Health Information, Consent to Treatment, Medical Records, and Telemedicine.
[2] Relevant legislation includes, but may not be limited to: the *Food and Drugs Act*, R.S.C, 1985, c. F-27; the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*); the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 (hereinafter *NSAA*); and the *Drug and Pharmacies Regulation Act*, R.S.O.1990, c. H.4 (hereinafter *DPRA*).
[3] Sections 2(1)(c), 2(5), O. Reg. 865/93, Registration, enacted under the Medicine Act, 1991, S.O. 1991, c.30; Changing Scope of Practice policy; The Practice Guide.
[4] An appropriate clinical assessment includes an appropriate patient history, as well as any other necessary examinations or investigations.

c) consider the risks and benefits of prescribing the chosen drug (including the combined risks and benefits when prescribing multiple drugs and the risks and benefits when providing long-term prescriptions); and
d) obtain informed consent.[5]

Relying on an Assessment Undertaken by Someone Else / Prescribing with no Prior Assessment

4. Physicians are permitted to prescribe on the basis of an assessment conducted by someone else.[6] When doing so, physicians **must**:

   a) have reasonable grounds to believe that the person who conducted the assessment had the appropriate knowledge, skill, and judgment to do so;[7] and
   b) evaluate the assessment and judge it to be appropriate.

5. If no prior assessment of the patient has been undertaken, physicians **must** only prescribe:

   a) for the sexual partner of a patient with a sexually transmitted infection who would not otherwise receive treatment, and where there is a risk of further transmission;
   b) prophylaxis (e.g., oseltamivir) as part of a public health program operated under the authority of a Medical Officer of Health; and/or
   c) post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne pathogen.

Content of Prescriptions

6. Physicians **must** ensure that the following information is included on every written or electronic prescription:

   a) the prescribing physician's printed name, signature (or electronic signature), and address;
   b) the patient's name;
   c) the name of the drug;
   d) the drug strength and quantity;

[5] For more information on consent, please refer to the College's Consent to Medical Treatment policy.
[6] The prescribing physician is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment.
[7] In most circumstances, this will require that the physician know the person conducting the assessment and be aware of his or her qualifications and training. In some limited circumstances, such as large health institutional settings, the physician may be able to rely upon his or her knowledge of the institution's practices to satisfy him or herself that the person conducting the assessment has the appropriate knowledge, skill and judgment.

e) the directions for use;
f) the full date the prescription was issued (day, month, and year);
g) refill instructions, if any;
h) if the prescription is for a monitored drug[8], the prescribing physician's CPSO number[9] and an identifying number for the patient[10] (unless certain conditions set out in regulation are met)[11];
i) if the prescription is for a fentanyl patch, additional requirements apply (these are set out in provision 36 and 37 of this policy); and
j) any additional information required by law.

7. Physicians **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (for example, the patient's weight where this information would affect dosage, or the patient's date of birth where this information would assist in confirming the patient's identity).

8. Physicians **must** ensure that written prescriptions are legible.

Authorizing and Transmitting Prescriptions

9. Physicians **must** authorize every prescription in one of three ways: with a written signature, electronically, or verbally[12].
   a) When authorizing prescriptions with a written signature, physicians **must** ensure that the signature is authentic and unaltered (electronic signatures may be acceptable if they meet the requirements of the Ontario College of Pharmacists[13]).[14]
   b) When authorizing prescriptions electronically, physicians **must** authorize the prescription themselves. Physicians **must not** permit other members of staff to authorize a prescription unless there is a direct order or medical directive in place, and if

[8] See Section 2 of the NSAA for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website at: http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx.
[9] NSAA.
[10] For example, a Health Card number. See the full list of approved forms of identification here: http://www.health.gov.on.ca/en/public/programs/drugs/ons/publicnotice/identification_list.aspx.
[11] See Sections 3 and 6 of the *General*, O. Reg., 381/11, enacted under the *NSAA*.
[12] There are some limitations on the use of verbal prescriptions (for example, narcotics cannot be authorized verbally[12]). Physicians can contact the pharmacist if they are uncertain about whether a particular verbal prescription is permitted. The Ontario College of Pharmacists (OCP) created a summary of federal and provincial laws governing verbal prescription requirements, which can be found here: http://www.ocpinfo.com/library/practice-related/download/Prescription%20Regulation%20Summary%20Chart%20(Summary%20of%20Laws).pdf.
[13] For more information, see the Ontario College of Pharmacists' website: http://www.ocpinfo.com/regulations-standards/policies-guidelines/unique-identifiers/
[14] Section 40(4) a) of the *DPRA*.

so, there **must** be a mechanism within the system to identify who authorized the prescription and under what authority.

10. Physicians **must not** create duplicate copies of a prescription (except for the purposes of retaining a copy in the patient's medical record). If physicians wish to provide a copy of the prescription to their patients for information purposes, it **must** be provided in a format that does not resemble a prescription (e.g. paper receipt).

11. Regardless of the method of transmission, physicians **must** ensure that patient privacy and confidentiality are protected.[15]

Respecting Patient Choice When Choosing a Pharmacy

12. Physicians **must** respect the patient's choice of pharmacy.

13. Physicians **must not** attempt to influence the patient's choice of pharmacy unless doing so is in the patient's best interest and does not create a conflict of interest.

Communicating with Pharmacists

14. Physicians **must** respond in a timely[16] manner when contacted by a pharmacist or other health-care provider involved in the care of a patient.

Documentation

15. In addition to complying with the general requirements for medical records[17], physicians **must** specifically document all relevant information regarding the drugs they prescribe. Physicians **must** do this by either retaining a copy of the prescription in the patient's medical record or by documenting the information contained in the prescription (as set out in provision 6, a-j of this policy).

16. Physicians **must** also document the type of prescription it is (e.g. verbal, handwritten, or electronic) and comply with any applicable requirements for the documentation of patient consent, as set out in the College's *Consent to Treatment* policy.

[15] Obligations with respect to the security of personal health information are set out in Sections 12 and 13 of *PHIPA*. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's Guidelines on Facsimile Transmission Security.
[16] The timeliness of the communication will depend on a variety of factors, including the degree to which any delay may impact patient safety.
[17] Sections 18-21 of the *Medicine Act, General Regulation*. For full details of the requirements concerning medical records, see the CPSO's Medical Records policy.

Monitoring Drug Therapy

17. Physicians **must** ensure that appropriate monitoring protocols are in place to identify emerging risks or complications arising from the drugs they prescribe.

18. Physicians **must** inform patients of:

    a) the follow-up care required to monitor whether changes to the prescription are necessary; and
    b) the patient's role in safe medication use and monitoring effectiveness.

19. If patients do not comply with an agreed-upon plan for prescription monitoring, physicians **must** consider whether continued prescribing is safe and appropriate by weighing the risks of continuing prescribing against the risks of discontinuing prescribing.

20. If, in the physician's judgment, drug therapy is not effective or the risks outweigh the benefits, physicians **must** consider discontinuing the prescription (specific expectations for discontinuing narcotics and controlled substances are set out in provisions 34 – 35 of this policy).

21. Whenever possible, physicians **must** only discontinue prescribing following discussion with the patient.

Prescription Refills (also known as Repeats or Renewals)

22. Physicians **must** review and authorize all requests to refill a prescription unless this task is delegated to staff[18] or the person authorizing the refill is a regulated health professional with the authority to prescribe.

23. Physicians must ensure that all requests for refills and all authorized refills are documented in the patient's medical record.

24. Physicians **must** ensure that procedures are in place to monitor the ongoing appropriateness of the drug when prescribing refills (for example, by conducting periodic re-assessments).

25. Physicians **must not** adopt blanket "no refill" policies.[19] While some physicians may rarely, if ever, write prescriptions with refills, physicians **must** decide whether or not to prescribe refills on a case-by-case basis, with consideration for the circumstances of each patient.

[18] If physicians are delegating this responsibility to staff, they must do so in accordance with the CPSO's Delegation of Controlled Acts policy.

Redistributing Returned Drugs

26. Because the integrity of the drugs cannot be ensured, physicians **must not** redistribute drugs that have been returned by a patient.

27. Physicians **must** dispose of returned drugs in a safe and secure manner (e.g. at the pharmacy).

Drugs That Have Not Been Approved for Use in Canada ('Unapproved Drugs')

28. Physicians **must not** prescribe drugs that have not been approved for use in Canada (i.e., drugs for which Health Canada has not issued a Notice of Compliance) except in the limited circumstances permitted by Health Canada.[20]

Distributing Drugs without a Prescription (e.g. Drug Samples)

29. When providing drugs to patients without a prescription[21] (e.g. drug samples), physicians **must** continue to meet all of the relevant requirements that apply to prescribing generally, including those related to patient assessment, documentation, and prescription monitoring.

30. When providing drugs to patients without a prescription, physicians **must** ensure that no form of material gain is obtained for the physician or for the practice with which they are associated (this includes selling or trading).

[19] A blanket "no-refill policy" means that a physician will not authorize refills for any patient, for any drug, in any circumstances. A blanket no-refill policy is a rigid position that prevents physicians from exercising their independent clinical judgment. This approach is not consistent with patient-centered care and has no clinical basis.

[20] For more information, see Health Canada's Notice of Compliance webpage. 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.

[21] Small amounts of drugs are sometimes provided to patients without a formal prescription for the immediate treatment of acute symptoms or to evaluate the clinical effectiveness of the treatment.

Narcotics and Controlled Substances

Narcotics and controlled substances[22] (including prescription opioids and methadone) can help support the safe, effective, and compassionate treatment of acute or chronic pain, mental illness, and addiction. However, these drugs require special consideration given that they are susceptible to diversion, misuse, and/or abuse, and many carry a risk of dependence and overdose.

Before Prescribing Narcotics and Controlled Substances

31. Before initiating a prescription for a narcotic or controlled substance (or continuing a prescription initiated by another prescriber), physicians **must**:

    a) consider whether the narcotic or controlled substance is the most appropriate choice for the patient;
        i. if there are no appropriate or reasonably available alternatives, physicians **must** document this fact in the patient's medical record;
    b) consider the potential risks associated with prescribing, and take reasonable steps to mitigate those risks, consistent with any relevant practice standards, quality standards, and clinical practice guidelines;[23]
    c) take reasonable steps to review the patient's prescription history as it relates to narcotics and controlled substances;
        i. for example, by contacting the patient's pharmacist or other treating physicians, or by reviewing digital sources of information regarding the patient's prescription history[24];
    d) establish treatment goals with the patient, including realistic goals for improvement and a plan for discontinuing prescribing should the risks outweigh the benefits; and
    e) obtain informed consent;
        i. in order for consent to be informed, physicians **must** inform patients of the risks associated with the drug being prescribed, including any risk of dependence, withdrawal, diversion, and overdose.

[22] Narcotics and Controlled Substances are defined in the in the *CDSA* and the *NSAA*. They include narcotic analgesics (e.g. Tylenol 3 and OxyNEO), methadone, and non-narcotic controlled drugs such as methylphenidate (e.g. Ritalin), benzodiazepines (e.g. Valium), and barbiturates (e.g. phenobarbital).
[23] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.
[24] For example, physicians in many parts of Ontario can now access a patient's prescription drug history (including narcotics and controlled substances) via the Digital Health Drug Repository. For more information about accessing the Digital Health Drug Repository, see the Digital Health Drug Repository Fact Sheet.

Additional Expectations when Initiating a Prescription for Opioids for Chronic Pain

32. In addition to the expectations set out in provision 31 of this policy, physicians who prescribe opioids for chronic pain **must** be aware of and seek access to digital sources of information regarding patients' opioid prescription history when such sources are available.

    a) For example, many physicians are now able to access a patient's opioid prescription history via the Digital Health Drug Repository[25].

33. When a patient's opioid prescription history is available and accessible to the physician, the physician **must** access and review it prior to initiating a new prescription for opioids for chronic pain.

When Prescribing Narcotics and Controlled Substances

34. When prescribing narcotics or controlled substances (or continuing a prescription initiated by another prescriber) physicians **must**:

    a) meet the general requirements for prescribing that are set out in this policy, as well as any other relevant policies and/or legislation;
    b) consider any relevant practice standards, quality standards, and clinical practice guidelines, and apply them as appropriate (for example, to determine a safe and effective dose);[26] and
    c) inform patients of how to safely secure, store, and dispose of any unused medication (especially in circumstances where locked storage is considered critical, such as prescription opioids and methadone).

Tapering and Discontinuing Narcotics and Controlled Substances

35. Physicians must not taper patients inappropriately or arbitrarily. Physicians are reminded that it is not always possible or appropriate to taper below a specific dose, nor is it usually appropriate to suddenly or rapidly taper prescriptions.

36. When tapering or discontinuing narcotics and controlled substances, physicians must:

[25] For more information about the Digital Health Drug Repository, and in order to gain access, see the Digital Health Drug Repository Fact Sheet.

[26] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.

a) proceed with consideration for the safety and well-being of the patient;
b) consider and apply, as appropriate, relevant practice standards, quality standards, and clinical practice guidelines;[27]
c) explain to the patient the rationale for tapering or discontinuation and provide a good-faith opportunity for discussion;
d) whenever possible, make decisions with respect to tapering or discontinuation in collaboration with the patient; and
e) carefully document their decision-making and any discussions with the patient.

Prescribing Fentanyl Patches

37. When prescribing fentanyl patches, physicians **must** include the following additional information on every prescription:[28]

    a) the name and address of the pharmacy where the patient has chosen to fill the prescription; and
    b) a notation that it is the patient's first prescription for fentanyl patches when the following conditions are met: 1) the physician has not previously prescribed fentanyl patches to that patient, and 2) the physician is reasonably satisfied[29] that the patient has not previously obtained a prescription for fentanyl from another prescriber.

38. Physicians **must** also notify the pharmacy directly, either by telephone or by faxing a copy of the prescription.

"No Narcotics" Prescribing Policies

While some physicians may rarely, if ever, prescribe narcotics or controlled substances in practice30, arbitrarily refusing to prescribe these drugs in all cases and without consideration for the circumstances of the patient may lead to inadequate patient care.

[27] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.
[28] *Safeguarding our Communities Act, 2015*. Physicians can find more information about their obligations under the Act in the College's *Patch-for-Patch Fentanyl Return Program: Fact Sheet*.
[29] A physician may be reasonably satisfied based on his or her discussions with the patient, as well as any other information available to the physician.
[30] For example, because the physician practices in an emergency room setting and is unable to provide appropriate follow-up care and monitoring.

39. Unless the prescribing of narcotics and controlled substances falls outside of the physician's scope of practice or clinical competence[31], or the physician has a restriction imposed by the College prohibiting prescribing, physicians:

    a) **must not** adopt a blanket policy refusing to prescribe narcotics and controlled substances without exception, and
    b) **must** decide whether to prescribe on a case-by-case basis with consideration for each patient.

Reporting the Loss or Theft of Narcotics or Controlled Substances

40. Physicians **must** report the loss or theft of narcotics and/or controlled substances from their possession to the Office of Controlled Drugs and Substances, Federal Minister of Health, within 10 days.[32]

Drug Storage

41. Where physicians stock narcotics and controlled substances, they **must** be securely and appropriately stored in the office to prevent theft/loss.

[31] Physicians with primary care practices are reminded that given their broad scope of practice, there are few occasions where scope of practice would be an appropriate ground to refuse to prescribe all narcotics and controlled substances.
[32] Section 55(g) of the *CDSA*, *Narcotic Control Regulations*; Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, S.O.R./2000-217, enacted under the *CDSA*. These obligations are also set out in the CPSO's Mandatory and Permissive Reporting policy.