Physician/Pharmacist 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 patients are asked to return any used or unused patches 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 possible, the physician should also write the actual pharmacy and location in which the prescription will be dispensed to decrease the possibility of prescription duplication.

When the physician writes this on the script, must pharmacists comply?

As you are aware, a prescription is essentially "permission" for a particular product to be dispensed to 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 not to follow the instructions of the prescriber, their decision should be discussed with the patient, documented, and discussed with the prescriber.

Will the Ontario College of Pharmacists support me on this?

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

Currently, OCP does not have a "Best Practice" recommendation on Fentanyl Patch 4 Patch, 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.

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**Adapted from the Peterborough County-City Health Unit*

Why don't the physicians just not issue any refills and have the patches returned to them before issuing the 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 accustomed to handling new and discarded medications on a daily basis.

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

Has patient education regarding appropriate disposal and handing out disposal containers been considered 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 the patient be reminded that they must return all used patches. If it happens again, the patient is to receive one dosing per period until the doctor can be reached. It is recommended that the patient see their physician to decide if it is appropriate to continue with this medication.

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

Yes, this is expected to be a one-time occurrence and should be documented as such.

How should the used patches be stored?

It is recommended that patients stick the used patches onto the provided sheet of paper (with no overlap) so that each patch can easily be recognized and accounted for. Clear tape can be used on the patch corners. Each time a patch is placed on the return sheet, the person doing so should record the date and their initials. These sheets will be made available through the public health website (see example).

Remind patients to 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 pharmacy, the used patch sheets should be placed into the pharmacy's drug disposal bin to be removed and destroyed on a regular basis as per pharmacy protocol.

**Adapted from the Peterborough County-City Health Unit*

How do we handle a vacation supply (larger quantity than patient has returns for)?
Discuss the vacation plans with the patient to determine the length of time that they will be away. 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 the patient must 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 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?
In a similar way in which pharmacy delivery personnel collect money, drug cards, expired medications, and other items such as signatures under the Narcotics Safety and Awareness Act 2010, 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 Narcotics Safety and Awareness Act 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 immediately.

What do I do if I encounter what I suspect to be a counterfeit patch?
Advise the patient that it is a criminal offense to unlawfully obtain narcotics and that they must bring in all the used patches before you can dispense more. If the pharmacist suspects the patient is involved in any type of fraudulent or drug diversion activity, he/she may consider notifying local law enforcement authorities

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