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Narcotic Deliveries

Last fall the *Narcotics Safety and Awareness Act, 2010* came into force. It stipulated, among other things, that an individual must provide suitable identification in order to receive narcotic medications from a pharmacy. Long term care and retirement facilities are not exempt from this requirement.

We have modified our *Delivery Verification Form* to allow for the entry of an identification number. While Driver's License and Health Card numbers are approved forms of identification, few nurses wish to use them, for privacy reasons. Facility employee numbers or *CNO* membership number may be better options. Please be sure to include an *ID* number on the form. Compliance has cited homes in some jurisdictions for omitting one.

Morphine Returns

Just one month ago we were all wondering if we would ever see an ampoule of morphine or hydromorPHONE (Dilaudid®) again. Elaborate plans were made to preserve and reallocate the discontinued ampules that were still present in some facilities.

Limited production of morphine has resumed and we have been able to access a good supply. Physicians should once again consider it for severe pain, where an injectable narcotic is their first treatment choice. Dilaudid® is not as readily available, but we can easily use morphine in its place after converting the dose, if necessary.

Pradax LU Coverage

Pradax® (dabigatran) is indicated for stroke prevention in non-valvular atrial fibrillation. The 110 and 150 mg (taken orally twice daily) strengths are now covered under *LU Code 431,* although coverage criteria are quite restrictive.

The first condition for coverage is warfarin failure after an adequate trial (a minimum of two months). If at least 35% of INR results fall outside the target range, substitution with Pradax® is covered. Coverage would also be extended when warfarin is contraindicated or where the INR cannot be regularly monitored. This latter situation could apply where a confused resident refuses to provide a blood sample when confronted by a lab technician with a phlebotomy kit.

Coverage will not be extended to patients with poor (GFR < 30ml/min) or unstable renal function. Canadian guidelines recommend a dose of 110 mg twice daily for those over 80 years of age or where GFR is 30 – 49 ml/min). For younger patients or those with better renal function, 150 mg twice daily is recommended.

Since there is no specific antidote to a bleeding event caused by Pradax® (unlike vitamin K for warfarin related bleeding), a bleed can have a devastating impact. There is also no test available to quantify the anticoagulant action of Pradax®. These are two significant deterrents to its use. Still, its effectiveness, simple dosing regimen, limited interaction profile and lack of testing burden make Pradax® an appealing choice in some cases.

Don't Trust Those A1Cs

We've come to rely upon the hemoglobin A1C as an indicator of "long-term" glucose control. While it is a wonderful marker, many anemias can yield artificially low (normal or near normal) A1Cs. In residents with the Sickle Cell or Thalassemia trait, recent hemorrhage or low hemoglobin combined with low hematocrit, glucometer results from the past week or two will be more reliable. A 4-fructosamine level gives the most accurate result.

GeriatRx PHARMACY

Prepared by Randy Goodman
Certified Geriatric Pharmacist