

# PHARMACY NEWSCAPSULE

Wisconsin Department of Health Services

Division of Quality Assurance

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## **Is this the same? Medication Dosage and Salt Forms** by Doug Englebert, R.Ph.

There are certain groups of medications that contain items such as iron, calcium, sodium, and potassium that are present in many formulations. These formulations are often confused with what physicians actually order. Why does this occur?

Products like iron and calcium may come in many different salt forms. For example, iron supplements are available as ferrous sulfate, ferrous gluconate, and ferrous fumarate, each of which delivers a different amount of elemental iron. The amount of elemental iron in the product determines the effective dose of iron a patient receives. Confusion may arise when a physician orders a specific dose of elemental iron and allows the facility or pharmacist to choose the product. For example, a physician may order 60 mg of iron. The facility or pharmacy may provide Ferrous sulfate 324 mg or 325 mg which delivers 65 mg of elemental iron; Feosol® 200 mg which delivers 65 mg of elemental iron; or, Ferrous gluconate 246 mg, two tablets, which delivers 28 mg of elemental iron per tablet for a total of 56 mg in two tablets. Although the dosage can vary, the elemental iron delivered is almost the same.

Confusion may be further increased if physicians order specific iron salts and express the iron in elemental dosages. In some cases the labeling of the product being used may express the dose differently than the order and confuse staff who are administering the medication.

Facilities can decrease confusion and medication errors involving salt forms of medication. First, facilities may use one consistent product. For example, a specific iron salt form may be chosen; e.g., Ferrous Sulfate. Second, the facility may ask physicians to write orders for iron in a consistent manner that matches the product the facility is using; this will assure that the resident receives the correct dose of iron. Third, if patients are switching salts of a product such as from calcium carbonate to calcium gluconate, a pharmacist should be involved to ensure that patients are being converted to equal or like dosages. Finally, providing easy-to-understand labeling related to dosage is important so that everyone is on the same page as to the elemental content of the tablet.

## New Medications

Brand Name	Generic Name	Use
<b>Bepreve</b>	Bepotastime	Eye drop for allergic conjunctivitis.
<b>Extavia</b>	Interferon	For relapsing multiple sclerosis
<b>Livalo</b>	Pitavastin	Cholesterol lowering drug
<b>Multaq</b>	Dronedarone	Antiarrhythmic for atrial fibrillation or flutter
<b>Onglyza</b>	Saxagliptin	For type 2 diabetes
<b>Sabril</b>	Vigabatrin	Antiepileptic medication
<b>Saphris</b>	Asenapine	Atypical antipsychotic medication
<b>Vibativ</b>	Telavancin	Antibiotic for skin infections
<b>Cambia</b>	Diclofenac	Oral solution for migraines
<b>Embeda</b>	Morphine/Naltrexone	Long acting pain control

## Consultant Corner by Doug Englebort, R.Ph.

There are many questions surrounding controlled substances and the requirements of the Drug Enforcement Administration (DEA). For the next few issues we will address questions and provide current DEA and State of Wisconsin requirements. The first set of questions that we will address involves emergency kits in nursing homes.

Emergency kits in nursing homes are allowed. The pharmacy codes in the State of Wisconsin specifically state the following:

### **Phar 8.11 Controlled substances in emergency kits for long term care facilities.**

Long term care facilities which are not registered with the DEA shall meet all of the following requirements regarding emergency kits containing controlled substances:

- (1) The source of supply must be a DEA registered hospital, pharmacy or practitioner.
- (2) The pharmaceutical services committee of the facility shall establish security safeguards for each emergency kit stored in the LTCF which shall include the designation of individuals who may have access to the emergency kits and a specific limitation of the type and quantity of controlled substances permitted to be placed in each emergency kit.
- (3) A pharmacist shall be responsible for proper control and accountability for such emergency kits within the LTCF which includes the requirement that the LTCF and the providing DEA registered hospital, pharmacy or practitioner maintain complete and accurate records of the controlled substances placed in the emergency kits, the disposition of those controlled substances, plus the requirement to take at least monthly physical inventories.
- (4) The pharmaceutical services committee will establish the emergency medical conditions under which the controlled substances may be administered to patients in the LTCF which shall include the requirement that medication be administered by

authorized personnel only as expressly authorized by an individual DEA registered practitioner and in compliance with all applicable federal and state laws.

(5) Noncompliance with this rule may result in revocation, denial or suspension of the privilege of having or placing emergency kits, containing controlled substances, in LTCF.

**The state rules for nursing homes state the following:**

**DHS 132.65 (4) EMERGENCY MEDICATION KIT.** (a) A facility may have one or more emergency medication kits. All emergency medication kits shall be under the control of a pharmacist. (b) The emergency kit shall be sealed and stored in a locked area.

**QUESTIONS AND ANSWERS**

**Q:** We are being told by our pharmacy that we cannot access the emergency kit without their authorization. When is a nurse allowed to remove a controlled drug from an e-kit?

**A:** Controlled drugs in e-kits are prescription controlled drugs and must be treated in the same manner as all other controlled drugs. Therefore, before a drug can be removed, there must be a valid written prescription or an emergency verbal order for a specific resident.

**Q:** What is a valid, written prescription for a controlled substance?

**A:** In order to be considered valid, a prescription for a controlled drug in any schedule must be issued for a legitimate medical purpose by a practitioner acting in the usual course of sound professional judgment. Each prescription must be dated **and signed by the practitioner** on the date it is issued and contain all of the following:

1. The full name and address of the patient
2. The drug name, strength, dosage form, quantity prescribed, and directions for use
3. The name, address, and DEA registration number of the practitioner
4. The authorized number of refills if a Schedule III–V

In most cases, a chart order written by the physician or a chart order written by the facility nurse based on a verbal order from the practitioner will not be considered a valid written prescription. (If the physician is in the facility and writes a chart order that contains all of the information noted above and then faxes that order to the pharmacy, it is a valid prescription for controlled substances.)

**Q:** When can an oral prescription order be accepted for controlled medications?

**A:** Oral prescriptions from a physician to a pharmacist are allowed for Schedule III-V if the pharmacist promptly reproduces them in writing and they contain, except for the the physician signature, all information required for a valid prescription. Oral prescriptions for Schedule II drugs are only allowed in an emergency situation. In such cases,

physicians may only authorize and pharmacies may only dispense a quantity limited to the amount adequate to treat the patient during the emergency period. For Schedule II drugs, a follow up written prescription must be sent to the pharmacy within seven days.

**Q:** What is considered an emergency?

**A:** An emergency means:

- (1) immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user;
- (2) no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II; and
- (3) it is not reasonably possible for the prescribing practitioner to provide a written prescription for presentation to the person who will dispense the substance prior to dispensing.

**Q:** Can a nurse remove a controlled drug from an e-kit if they have received an oral order from the practitioner?

**A:** DEA rules require that the practitioner provide oral authorization or a faxed prescription to the pharmacist before a drug is dispensed. Consequently, a practitioner who gives a telephone order to the nurse in the facility must also ensure that the pharmacy receives either an oral “emergency” order or a written prescription order (which may be sent via facsimile).

Additional questions will be addressed in future issues. It is important to know that all of these DEA regulations have been in place for many years. Some of these regulations may create barriers to providing efficient care; however, it is still possible to provide care and comply with DEA requirements. Compliance can take many forms. Due to recent DEA enforcement activity, various providers are implementing plans to become compliant. Although these plans may look very different from one provider to the next, the current regulations allow differences to exist. If a specific plan is not working to meet the needs of patients, alternative plans that are compliant should be explored.

In addition, many efforts are underway to look at rule modification, including e-prescribing for controlled substances. As changes in rules occur, the practices surrounding controlled substances will also need modification.