Overall Comments:

- Be sure to provide adequate citations in the final report.
- Beware the “poison pill” option – an option that is so awful that no one would really select it.

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**Group #1 Meth Busters**
Group Members: Etsegenet Assefa, Louisa Chu, Dennis Go, Marshall Heaster, Marcie Hume, Kristen Kai, Robert Lambert, and Jill Mack

1.) A worst-case scenario is that controlling pseudoephedrine has no effect on domestic meth production and only the legitimate patient is harmed. Another worst-case scenario is that controlling of pseudoephedrine means that a lot of “bad” meth may hit the street and cause a lot more toxicity and death in users. A best possible scenario is that domestic meth production decreases significantly and so does meth use. Most likely Pseudoephedrine will become a schedule V nationally or at least be controlled in most states. We may not see any final drafts that give a pharmacist the power to dispense a small amount to a patient without a prescription for congestion relief.

Prescription only medication legend or controlled substance: It is easier to track than a log system. The public may be very unhappy to have to go to their PCP to get a prescription for a stuffy nose and it is inconvenient for prescribers. This plan would probably never pass or be implemented. This action would likely decrease meth diversion from U.S. pharmacies by close to 90%, but wouldn’t touch the real problem. There is no way to make this unobjectionable to prescribers/patients. Pharmacists may prefer because there would be no log, but the reality is it wouldn’t work.

2.) We would like to reduce methamphetamine production in the state of Washington by 25-50% by simply restricting the sales of pseudoephedrine. Similar numbers have been demonstrated in other states (Oklahoma) that have implement similar restrictions.
All forms pulled from market, including combos: manufacturers would fight this, patients would – pseudoephedrine is cheap and works well, most prescribers would probably fight this. This alternative might actually affect meth diversion in other ways. If it’s pulled from market there is no legitimate reason to be shipping into us, so it may be caught easier coming over border. This would limit diversion from pharmacies 100%, and possibly a good percentage overall. This is a Federal solution so it would be hard to implement, but wide reaching. Manufacturers may lose a lot of business due to no easy way for pts to treat congestion - possibly keep combinations on market.

3.) There are some undesirable side effects. Legitimate patients may not receive the relief that they need, and this would have to be solved through a primary care physician who may need to write a prescription. Another drawback is that the user of meth will always be there and the needs of the user will be met with foreign importation (mostly from Mexico) of meth. This meth is not always as safe, as cheap, or as good. The federal government will need to address illegal drug trafficking (which they are addressing) at our international borders. Leaving the law as is and hoping that current legislation controls diversion is another alternative. Again, it is a national problem, and limiting sales in pharmacies is just a "stop gap" measure. However, nobody would say anything, as this has just been passed and we haven't seen what effects it will have yet. It may send meth seekers into other states to get ingredients.

**Group 4 Expiration of CII Prescriptions**

Group Members: Quyen Nguyen, Linh Mai, Andrea Eberly, Jeff Loor, Geoff Meer, Jennifer Law, Nick Wyatt, Sareh Ghazanfarpour

1. **Alternative 1:** Instead of having schedule II prescriptions expire within 90 days as suggested, expiration can be extended to 6 months. This corresponds with other control substances (CIII and IV). However, no refills are allowed.

   Project outcome: If this alternative was completely implemented, the worst possible outcome is that it has absolutely no effect on patient safety or overuse of CII prescription drugs and negatively affects the legitimate patients needing these services. The best possible outcome includes a huge reduction in overuse of CII narcotics and much better therapy management for those on narcotic regimens. Realistically this would have little effect in either of these instances since there is not much difference between six months and a year when it comes to these prescriptions. This plan may reduce the number of narcotic overdoses and other unsafe narcotic side-effects by up to 10%. A side effect of this alternative is that these prescriptions are still valid up to six months from date of issue and still have potential to be unsafe.

2. **Expiration of schedule II prescriptions can be changed to expire within 90 days.** However, refills are allowed within this time frame (maximum of 2 refills). This allows prescribers to see patients more often for monitoring and decreases the
hassle of patients having to obtain several prescriptions. (We are now considering this alternative)

Project outcome: Again, the worst possible outcome is that the alternative has no effect and the best outcome reduces narcotic-related morbidity and mortality to near zero. Realistically this plan could allow for better follow-up and fewer adverse reactions to drugs given much later than intended. This plan will increase follow-up by doctors and may reduce adverse reactions by up to 50%. Undesirable side-effects include overbooking of doctors since patients will need to be seen every three months. These will eventually be reduced since with better care the patient may not need to be seen anymore at all.

3. We are proposing to change the expiration date of all schedule II prescriptions from one year to 90 days. Narcotics and stimulants are used to treat conditions that need careful monitoring and evaluation. Allowing patients to fill the prescription one year after the written date is unsafe. (The original alternative)

Project outcome: This will be the same as #2 except the patient would need to be seen monthly or the prescription sent to the pharmacy monthly in order to get the CII to the patient. Undesirable side-effects would be an undue burden on the doctor and the patient to see each other monthly and get the drugs they need, although this would be optimal for pain management.

Group 5 – Black Box Warning on Benzodiazepines
Rachel Nowak, Osama Saleh, Carolyn Sear, Ben Davis, BJ Gleason, Vivian Villanueva, Kevin Hiroo, Hae Young Zhang

Alternative #1 – Rescheduling Benzodiazepines from Schedule IV to III

The worst possible outcome if benzodiazepines were to be rescheduled from a Schedule IV to III is that this would not elicit change in prescribing habits, abuse, and awareness. This is due to the inherent lack of difference perceived by prescribers between Schedule IV and Schedule III drugs. A rescheduling may not on its own provide the intended effect of increased awareness due to the fact that there is no direct impact in the practice of health care providers. The best case scenario would be that a rescheduling would alert providers to the fact that Schedule III drugs have higher potential for abuse, addiction, and misuse than a Schedule IV.

Alternative #2 – Education (CE) to increase awareness among prescribers.

Providing educational opportunities to alert prescribers about the addiction potential of benzodiazepines among alcohol/drug abusing populations is a positive, collaborative approach to this problem. Prescribers would attend CE presentations in an effort to stay current on new medical information. A CE would provide a forum for the distribution of information regarding benzodiazepines, allowing for a more
in-depth discussion of this issue (when compared to a letter sent to prescribers). On the other hand, most prescribers that conscientiously attend CE events are inherently more diligent prescribers and, therefore, likely to be already aware of the impact of benzodiazepines. Consequently, CE’s might not specifically target the group of prescribers that most need this information. Another drawback would be the limited impact of this alternative, since not all prescribers would attend such a CE event, unless it was explicitly required.

Alternative #3 – Mass educational mailing

The worst possible outcome of implementing a mass mailing notification of the misuse potential of benzodiazepines in particular populations is that prescribers may be more reluctant to prescribe a benzodiazepine to a legitimate patient. The best possible outcome would be that prescribers would be made aware of the risks of overprescribing, particularly to populations that recent studies have shown are at greater risk for benzodiazepine misuse. Realistically the number of prescribers influenced to change their prescribing habits would be suboptimal due to an insincere consideration of the information contained in the warning letter. An undesirable side effect of this alternative is a high cost to benefit ratio. One way to mitigate the cost side of this option is to implement an electronic route of information distribution.

Alternative #4 – No action

The worst possible outcome of taking no action is the continued pattern of abuse, misuse, and over-prescribing of benzodiazepines along with the resulting costs, morbidity, and mortality. Realistically, with no intervention, the problem will not improve on its own. Doing nothing will have no appreciable effect on the use of benzodiazepines. The undesirable side effects of doing nothing include failure to increase awareness of benzodiazepine misuse. These side effects can be mitigated by taking action and being proactive. Doing nothing is the least favorable alternative to the primary goal of this project.

Group 6 – in stakeholders report

Group 7
Caroline Kimani, Catherine Ulep, Madeleine Fry, Casey Lirot, Suejin Park, Chris Yocom, Dimay Wang, Caroline Wu.

Project outcomes assignment
1. Applying mandatory picture and description only to high risk sound-alike and look-a-like drugs that are identified by JACHO. This method is feasible. It is informative to both patient and pharmacy staff as compared to the current method of tall man letters or messages on the computer. These drugs would be dispensed
more accurately hence reducing errors. On the other hand this option does not solve the problem of medical errors while dispensing drugs that do not have look-alikes or sound-alikes.

2. Use of auxiliary labels with description instead of requiring a picture. This might not be very effective since pharmacies would need extra space to store all the auxiliary labels. Also increases the likelihood of placing a label on the wrong drug. Pharmacists might also be reluctant to buy all auxiliary labels for each drug since there are different manufacturers for the same drug.

3. Allow the implementation of law in a step-wise fashion. Use auxiliary labels then by the year 2010 all pharmacies should be able to generate label with pictures from the computer. This alternative is realistic for it allows pharmacies to obtain the necessary software without too much pressure.

Group 8 Spacers, Project Outcomes
Reilly Benz, Heidi Colpitts, Viet Lam, Brian Seiki, Alesya Vlasenko, Holly Warner

Alternatives:
1. Attempt to make it possible for pharmacists to prescribe spacers at their discretion without an existing protocol. This way a pharmacist can dispense a spacer to a patient if he or she thinks it will likely improve the patient’s therapeutic outcome.

   -If we implemented this option, it would create less paper work for pharmacists. This would be the ideal option because it would require the least amount of effort on the part of the primary care provider and the pharmacist while still accomplishing the main goal of increasing therapeutic outcomes for patients with metered dose inhalers.

2. Petition manufactures which produce “Rx Only” spacers to change classification of their products such that they could be sold OTC. This would increase the availability of spacers in drug stores and other pharmacies.

   -The main problem with this is that upon contacting some manufacturers, they say that the classification is not determined by them. If spacers were made OTC though, some insurance companies may discontinue coverage, and if patients are forced to pay, it may actually decrease availability because patients may not be able to afford them.

3. Another option is to leave the issue where it is.

   -If we keep it the way it has been many patients will continue to use their inhalers improperly. This results in the use of more inhalers, which would continue to cost us more money than providing a spacer to ensure correct usage.

Group 9 – Tramadol Scheduling
Holly Dirks, Michael King, Amy Little, Adam McCown, Pavel Mitin, Brad Siegfried, Gigi Wong

Alternative Outcomes:
1. Send out a 'Dear Doctor' letter explaining the issue with Tramadol. It would be to the effect of its opiate activity and potential for addiction/abuse. This would be very easily implemented. If funding were an issue we might be able to contact an AMA journal that has a weekly e-update that we could submit a brief paragraph to. Follow up contacts with doctors may be necessary to ensure an adequate response level.

2. **Start a Med Watch type program in the state of Washington.** This plan is not likely to be implemented. There is no state level organization currently, and funding would be difficult. Also, this hinges on physician or health care provider reporting any adverse events with Tramadol. Since we do not have much concrete evidence, physicians may be hesitant to comply with reporting incidents. Additionally, some kind of contact, like plan 1, would be required to make the physicians aware of the issue in the first place.

3. Do nothing. This is not a very good option in terms of pursuing our goal, but it may be more realistic. Without concrete evidence to a direct problem (which we don’t currently have the ability to produce), this may be a dead-end.

**Group 10.** Generic Substitution
Frances McGaugh, Michael Fallon, Whitney Stoffel, Jasmine Chase, Thu Dang, Ching Chow, Melvin Wang

Alt 1: Make generic substitution mandatory except whenever mandated on a prescription to “dispense brand only”. This will save time and money when brand name drugs become generic.
Worst possible: Pharmacist’s choice to substitute generic product was incorrect and cause patients to suffer adverse reactions. Drug companies lose profit and start campaigns that say pharmacists are incompetent in making the right decisions for patient’s drug therapy. This could potentially create public distrust in pharmacists and we would lose our jobs.
Best possible: Pharmacists save time in dispensing and spend more time in medication management. Patients end up saving more money and feel better at the same time. Doctors actually learn to trust us and our working relationship becomes even better.
Reality check: Probably a little of everything above.

Alt 2: Same as #1, but allow Pharmacists to accept responsibility for brand to generic interchange.
A negative side effect of this legislation could be that money minded pharmacists would select products based upon which pays them the most money. However, there is already legislation in place that requires 60% of the savings be passed onto the consumer, so this should not be an issue. Besides, it is pharmacists ethical duty to help patients by dispensing the most efficacious and affordable medications available.

Alt 3: Make the dispensing of brand or generic solely at the discretion of the Pharmacist. Push the view of the Pharmacist as the ”drug expert”, and allow Pharmacists to accept liability for the substitution.
Since we are the medication experts, we have extensive knowledge about medication, so performing a simple task of generic substitution doesn't post any problem. Especially with the help of the orange book we are basing our decisions on solid evidences. Pharmacists can utilize their expertise to finish up the treatment plans by choosing the best medications for the patient by communicating with patients and can even monitor their medication use. This would provide physicians more time to focus on diagnosing and prescribing and can trust pharmacists’ knowledge to finish up the process. Essentially, all physicians need to do is sign the prescription to imply that they have examined the patient and now authorizing this treatment. Of course, we will be liable for our part of the therapy. This plan can take off the workload and some liabilities off the physicians. This plan maximizes physicians’ and pharmacists’ expertise.

Alt 4: Make dispensing of generic medications mandatory with the exception of a select list of low therapeutic index medications. Those medications listed would only be dispensed as generic with the consultation of the patient’s physician. This option could also be with or without Pharmacist responsibility for generic substitution. 

Worst: Pharmacists still have to spend time calling up physicians for consultation for those narrow-therapeutic index medications.

Best: Pharmacist may not have to accept liability for making generic substitutions because the primary care provider still accepts most of the responsibility in prescribing the correct medication.

Get real: This alternative sounds feasible to ensure the patient’s safety.

**Group 12 – Extension of C-II Partial Fill Completion Time Limit**

Group Members: Ashley Bean, Amy Chang, Morgan Hutchings, Rachel Schreffler, Kathleen Thornton, Kelli Watari, Jeff White

Alternative 1:

- One alternative to this problem would be to extend the length of time allowed for a partial fill to 7 days. This would allow enough time to order any needed controlled medications and complete a fill under any normal circumstances including weekends and holidays.

- If this alternative is implemented, it would allow sufficient time to complete any partially filled schedule II prescriptions even on holiday weekends. Many pharmacies only perform a schedule II once a week, and so that is where the 7 days limit was decided upon. A drawback to this situation is that the sense of urgency in completing the prescription may be lost and the pharmacy may not work as quickly as they might if the 72 hour limit remained in place. However, schedule II narcotics are highly inventoried, so we feel the pharmacy will be confined by the status of the order and the duty to the patient rather than let the prescription be forgotten about.

Alternative 2:
• Another alternative would be to get rid of time restraint at all, so that there is no time limit after the original fill when the completed partial fill can be filled. In order to keep this from possibly slipping into making it possible to “refill” schedule II medications by dividing a large order several times, we would add that a schedule II medication can only be partially filled once. **Partial fills can only occur if the pharmacy has insufficient supply to fill the order.**

• The outcomes or impacts that may result if this alternative was completely implemented are that this can reduce chances of causing unnecessary pain to an individual who cannot get his prescription completely filled in a specified time period and reduces the expense of excessive doctor office visits. Also this can lead to the schedule II filling process becoming too lax by allowing patients to come in after most pharmacies returned unpicked up prescriptions to stock causing the patient to be in the same position they were in before.

Alternative 3:
• A third alternative would be to not allow partial fills of a schedule II prescription. If a pharmacy is unable to supply the whole amount written for they are not allowed to supply any. Patient would then be directed to another pharmacy.

• The worst possible situation that could result out of this alternative would be that a patient in a small town may not be able to get any medication at all if the one pharmacy in town is low on supply and the patient cannot travel to another pharmacy. The best that could come out of this would be that once a patient made it to a pharmacy able to provide all of the medication, the patient would not have to come back and the doctor would never have to rewrite a prescription that has passed the 72 hour mark. The only way to decrease the possibility of a patient not being able to receive any of a medication would be to require at least two pharmacies in any town or to require pharmacies to stock excessive amounts of schedule II medications to prevent the possibility of ever running out of stock. This alternative is a bit unrealistic, but proves the point of the highly restricted current law.