From: Tom Elliott <s 9(2)(a)>
Sent: Wednesday, 14 December 2022 3:48 pm
To: Consult
Subject: Re classifications of class B drugs

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Two whom it may concern,

I am writing feedback for the reclassification of class B drugs and therefore their ability to go from 1 month scripts to 3 month scripts.

I agree in principal this is a good idea as it reduces the significant burden on GPs/Psychiatrists especially for methylphenidate as it is a long term condition.
However for morphine/other opiates, there are two issues I see, 1) that Pharmacies will have to have significantly more stock of opiates on hand and could become a target for criminals (which is increasing in NZ) and 2 that patients will have less incentive to reduce their opiate use.

Kind regards,
Tom

Tom Elliott
Pharmacist

Hillmorton Hospital Pharmacy

waea pūkoro: s 9(2)(a) s 9(2)(a) | **īmēra:** s 9(2)(a)
Annex Rd Middelton, Christchurch

Te Whatu Ora – Health New Zealand
TeWhatuOra.govt.nz

From: Penny <s 9(2)(a)>
Sent: Monday, 19 December 2022 8:06 pm
To: Consult
Subject: Consultation: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs
Attachments: CAPA response to Pharmac proposal to amend Pharmaceutical Schedule Rules on Prescribing and dispensing 19Dec2022.pdf

Tēnā koe

Many thanks for the opportunity to provide feedback on the Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

Our response is attached

Ngā mihi nui

Penny

Penny Clark *Reg Pharm NZ (prescriber)*

Clinical Advisory Pharmacists Association (CAPA) – Chair
s 9(2)(a) s 9(2)(a)
s 9(2)(a) s 9(2)(a) *(work)*

Clinical Advisory Pharmacists Association (CAPA)

To: Pharmac

From: Penny Clark, Chair, CAPA

Date: 19 December 2022

Subject: **Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs**

Tēnā koe

Thank you for the opportunity to feedback on the consultation re the Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs
.
The Clinical Advisory Pharmacists Association (CAPA) is an association of pharmacists with postgraduate qualifications and includes many pharmacists working in primary care and the primary and secondary care pharmacist prescribers. Many pharmacist prescribers and clinical pharmacists work with people with chronic pain and several pharmacist prescribers work in palliative care.

We would like to make the following comments

- We support the electronic prescribing of controlled drugs in general
- We view the issues and subsequent requirements for long term medicines for ADHD and for opioid substitution therapy as different issues from those associated with the class B medicines used for pain, and therefore wish to differentiate between these in our response.
- We support the proposed changes for prescribing and dispensing of Class B drugs for methylphenidate, dexamfetamine for long term use or methadone where methadone is used for opioid substitute therapy, with some provisos as suggested below
- We do not support any changes to the prescribing and dispensing of class B controlled drugs that are used for pain, i.e., fentanyl, morphine, oxycodone, pethidine or methadone, for the reasons detailed below and suggest that the status quo of a maximum of a one-month prescription with a maximum of ten-day supply on repeat be continued.

1. **Methylphenidate, dexamfetamine and methadone**

Re methylphenidate and dexamfetamine

We agree that the current requirements for one monthly prescriptions for long term medications methylphenidate and dexamfetamine for attention deficit hyperactivity disorder (ADHD) and associated conditions make access difficult for patients and their whānau, add unnecessary cost and time for whānau as well as extra work for the general practitioner or prescriber and pharmacy. A three-monthly review by the prescriber is appropriate and therefore a three-monthly prescription logical.
We are also aware that these medicines may be subject to drug seeking and illicit use.
We therefore support the proposal to make methylphenidate and dexamfetamine for ADHD more accessible with three monthly prescriptions along with the one month dispensing requirement with some provisos.
The provisos would be that the process for these medicines continues to be recommended to be tightly controlled as at present to avoid further potential for diversion and/or abuse. This would include the best practice recommendations that as much as possible one prescriber(s) writes the prescription, an agreed pharmacy is used, and agreements are in place around no early prescriptions or dispensing as per present best practice.

Re methadone

We support the proposal to make methadone for opioid substitution therapy (OST) available with a three-month prescription, however, suggest that methadone remains more tightly controlled than methylphenidate and dexamfetamine with more regular dispensings and a maximum of weekly dispensing. The additional provisos would be that the process for methadone continues to be tightly controlled as at present to avoid further potential for diversion and/or abuse. This would include having named prescribers, pharmacies, supervision of dose and requirements around no early prescriptions or dispensing as per present requirements.

2. **Opioids for acute and chronic pain and palliative care. Fentanyl, morphine hydrochloride, morphine sulphate, oxycodone, pethidine and methadone (for pain)**

Opioids ideally should only be prescribed for acute, severe pain or palliative care with a few exceptions. We do not support these medicines being available on a three-month prescription due to the reasons outlined below. We therefore suggest that these medicines remain a maximum of one month prescription. Historically ten-day amounts being dispensed for class B opioids was introduced as a safety measure because of the large amounts being otherwise available in the community. There is no evidence that this risk has diminished whilst there is a known global opioid addiction crisis. We are therefore unsure why this rule would be changed at this time as the unintentional consequences could be far reaching.We would prefer that the ten day period of supply remained, but at the very least would recommend that the prescriber is enabled to determine the period of pick up, and that the number of units (e.g. tablets, ampoules) is required to be specified if the prescription is for prn use.

Acute pain:

People taking class B controlled drugs for acute pain need to be reviewed regularly to ensure that their pain is optimally managed and that there is no deterioration or escalation of use or dependence developing. It is equally important to also ensure a person doesn't accidently slip into long term use and unintended addiction after an acute pain episode such as post-surgery or post injury. Regular prescriptions force an awareness by the prescriber of

the frequency and amounts of the prescription. Rather than less regular review, increased frequency of reviews would be appropriate, and ideally the prescriber would restrict prescriptions to shorter duration e.g. two weeks. Allowing these to be up to three monthly prescriptions could be the beginning of a slippery slope to dependence and inappropriate long-term use plus misuse / excess amounts in the community. We would have particular concerns about prescriptions written after discharge from hospital where under the present rules it is not uncommon to see large quantities of Class B controlled drugs, as well as codeine and tramadol, dispensed under the one-month period of supply as the usual approach is for the maximum amount to be calculated and dispensed. Allowing up to a three-month prescription would add to the problem of excess opioids in the community and resultant opioid misuse disorder.

Palliative care pain:

People under palliative care require regular review to ensure pain is well managed as their needs may frequently change, generally with increasing pain medication requirements, rather than decreasing as with acute pain. As with acute pain but for different reasons a three-month prescription may leave the person unintentionally sub optimally managed.

This also raises a number of patient safety and wastage issues with people having large supplies at home if a month is dispensed at once, becoming targets for diversion and hence crime/ burglary, having larger unused amounts sitting in homes if a person changes medicines or passes away or for harm by inappropriate sharing of medications.

Chronic pain:

For people with chronic pain changing the duration of the prescription to three months may seem appropriate however, for the vast majority of people with chronic pain, there is no evidence of any benefit of long-term opioids in chronic pain management. However, there remains the potential for addiction and adverse effects including the development of opioid hyperalgesia which can go unrecognised and leads to increasing doses. Reviewing regularly is an opportunity to review appropriate use with the person. In the longer term there should be little need for long term prescriptions, in which case the workload for the GP or prescriber to review and write monthly would be lower. The emergence of electronic prescribing would make this management significantly less arduous.

We would suggest that prescription for Class B controlled drugs, other than methylphenidate, dexamfetamine and methadone (for OST), remain a maximum of one month, ideally retain the ten days supply rule or that the prescriber be able to specify the period of pick up.

Thank you for your consideration

Penny Clark
CAPA Chair
[redacted]

CAPA Board

Penny Clark, Chair

PGDipClinPharm(dist), PGCertPharmPres, MCAPA, FPSNZ, MNZHPA, RegPharmNZ(prescriber)

Dr Linda Bryant, Immediate past chair.

MClinPharm, PGDipHospPharmAdmin, PhD, PGCertPharmPres, NZOM, FNZHPA, FNZCP, FPSNZ, Gold Medal (PSNZ), MCAPA, RegPharm NZ (prescriber)

Bernie McKone, Vice Chair.

Dip Pharm, M Pharm (Distinction), FNZCP, FPS, Gold Medal (PSNZ), MCAPA, RegPharmNZ

Carolyn Woolerton, Treasurer.

MClinPharm. PGCertClinPharm(Prescribing), MCAPA, MPSNZ, RegPharmNZ (prescriber)

William Berry, Education

MPharm, PGDipClinPharm, MCAPA, MPSNZ, RegPharmNZ (prescriber)

Sanmarie Firestone, Website and communication

PGDipClinPharm(dist), PGCertHealSc (Pain and Pain Management), MCAPA, MPSNZ, RegPharmNZ

From: Ian Barr <s 9(2)(a)>
Sent: Tuesday, 20 December 2022 4:31 pm
To: Consult
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

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Feedback on proposal:

Whilst I agree that, *'Removing the ten-day dispensing rule from the Schedule would reduce the number of times people need to collect other Class B controlled drugs from a pharmacy, and removes the inconsistency between the Schedule Rules and the Misuse of Drugs Regulations'*, I do have major concerns about the large increase in Class B controlled drugs that will be supplied at any one time.
This will result in increased wastage when dosages are changed or when patients are deceased, or patients/carers may hold onto these medicines; this must surely have safety implications. I was led to believe that one of the reasons for the 10-day dispensing rule was for safety reasons; clearly that is no longer considered important.
Also, pharmacies will need to increase their controlled drug storage space, at considerable expense. If many pharmacies need to purchase additional CD safes, there will not be sufficient stock in NZ to have them purchased and installed by 1st February 2023. Pharmacies may not have sufficient space in their dispensary to accommodate additional or larger CD safes to meet the stafe storage of medicines requirements to the satisfaction of Medicines Control.

As an alternative suggestion, how about considering a 15-day dispensing rule? That would be 6 dispensings in a 90 day period, as opposed to the current 9 dispensings in 90 days. This would meet the aim of reducing the frequency of which people would need to collect class B controlled drugs from a pharmacy whilst reducing the safety implications of having such large amounts of controlled drugs in the community and reducing the impact of storage space on pharmacies.

Yours,

--
Ian M Barr
Consulting Pharmacist
Barham Pharmacy Group
s 9(2)(a)
s 9(2)(a)
s 9(2)(a)
Ph: s 9(2)(a)

From: Kyra Sycamore <[redacted]>
Sent: Tuesday, 20 December 2022 1:11 pm
To: Consult
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

Kia ora PHARMAC

Thank you for consulting on this issue. I have given it careful consideration and have settled on the following:

Methylphenidate and dexamfetamine
This proposal makes perfect sense. ADHD is a long term condition and 3-monthly prescriptions would increase access and improve medicines/health equity. Given the nature of ADHD, getting to the doctor every month can be enormously challenging for many people/whanau/carers. I agree with 3 month prescriptions.

Methadone
Again, this proposal makes perfect sense in relation to OST.

Morphine, oxycodone, fentanyl, methadone for pain
This is where I'm not convinced. For people with long term pain conditions, I agree with the proposal. There are however a significant number of people who will receive more medication than they need and I fear there is a significant risk in terms of increased rates of opioid dependence. I would like monthly scripts and 10 day dispensing to be the default. Longer scripts and monthly dispensing should only be funded if the script is endorsed/annotated as a LTC with pain, something that I think should be open to auditing.

I am aware that this consultation is about funding, not whether I agree with the legislation changes. As you can see, I don't agree with all of the amendments, but I think the funding arrangements can help to mitigate the risks.

The vast majority of prescribers in NZ are excellent but there are still a lot who will just prescribe whatever people ask for. I had a case [redacted] she was prescribed oxycodone, pregabalin, diazepam, paracetamol and ibuprofen, all from her GP. The oxycodone was supposed to be on a reducing scale but the patient refused to reduce it. The pregabalin was only started a week prior to admission and had been increased to the max dose within five days of starting. This was an example of very poor prescribing, simple as that. As a team on the ward, we agreed these medicines needed to be reduced and stopped. We spoke to the GP who agreed with our plan. We then spoke with the patient who refused all changes, and immediately contacted her GP **who agreed with her**. We called the GP again and it became very clear that the GP just can't say no to people if they pressure her in any way. This was a very worrying scenario where the GP was not doing the best for her patient. As it happens, we stopped all of the medicines and the patient is a lot better. She describes a fog lifting and her thoughts being so much clearer, and she is now able to look after her children.

I had another case (on the same ward at the same time unfortunately) who was prescribed Ritalin LA, clonazepam drops and tramadol. Her GP had been prescribing these for her regularly for at least the last 8 years. The patient and her partner were selling all of it. Another GP who can't say no.

My point is that some prescribers need training on assertiveness and how to say no to inappropriate requests. I also think prescribers, especially GPs, would benefit from additional education about the risks of dependence when opioids are taken regularly for more than a few weeks. If that training could come from somebody with lived experience of beating an opioid addiction, that would be ideal. As an example, the BBC documentary about pregabalin is extremely powerful. It's available on YouTube if you're interested.

Increasing supply between reviews increases the risks. If opioids are to be supplied on 3 monthly scripts with monthly dispensing, there has to be some work to mitigate those risks.

Community pharmacies in Christchurch have also expressed concerns about having to keep more opioids in stock to fill monthly prescriptions. We all see what's happening with dairy robberies in NZ. If diaries become better protected, and if pharmacies are carrying more stock, pharmacy staff are worried they will become the new target. I agree with their concerns.

Thanks very much

Kyra

Kyra Sycamore (she/her)
Mental Health Pharmacist
Te Waipounamu | Waitaha Canterbury

Phone: s 9(2)(a) or s 9(2)(a) or ext: s 9(2) | **Email:** s 9(2)(a)
The Princess Margaret Hospital | Cashmere Road, Christchurch 8022

Te Whatu Ora
Health New Zealand

Te Whatu Ora – Health New Zealand
TeWhatuOra.govt.nz

From: Highland Pharmacy <roxburgh@highlandpharmacy.co.nz>
Sent: Wednesday, 21 December 2022 1:34 pm
To: Consult
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

Under the Who we think will be interested section in the consultation page on the website, I think you missed a few groups. I'm thinking illicit drug dealers and opiate addicted people.

Alastair Forbes B.Pharm, RegPharmNZ
s 9(2)(a)
Highland Pharmacy Central
www.highlandpharmacy.co.nz
Highland Bike Hire
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107 Scotland Street
Roxburgh 9500
Ph 03 4468009
0800 HIGHLAND
Fax 03 4468621

From: Kirsten Simonsen <s 9(2)(a)>
Sent: Wednesday, 21 December 2022 2:09 pm
To: Consult
Subject: Controlled Drug legislation - changes to prescribing and supply

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Thank you for the opportunity to provide feedback on the proposed legislatory change.
My feedback will be in the form of general comments on these, and other concerns I have with controlled drug supply to patients, that may be addressed while Te Whatu Ora and Pharmac are considering this change.

1. Safety - health
I see a number potential problems with this proposal, some of which already exist:

- large quantities of controlled drugs/pain relief can encourage patients to not return for medical review at an appropriate time, e.g. post-operatively, when controlled drug use would be expected to reduce over a short time post-operatively
- large unused quantities of controlled drugs remaining in patient's homes
- potential to contribute to controlled drug misuse or dependence in the intended patient
- potential to contribute to controlled drug misuse or dependence in the wider family/whanau/social networks
- if the prescriber has not specified a quantity there is convention when dispensing 'as required' medicines/controlled drugs, for pharmacies to supply the maximum quantity allowable for full daily dosing (in this situation a pharmacy does not know what the prescriber intends, and wants to avoid inconveniencing a patient who is unwell). The changes will mean the effects of this will be greater than currently.

2. Safety - social, community
Dispensing of larger quantities of controlled drugs, will likely lead to larger unused quantities in patients homes prior to use or unused, with risk of:

- contributing to illicit drug use, the industry behind this and adverse social impacts
- pharmacies needing to stock larger quantities of controlled drugs but with limited secure storage capacity
- pharmacies having to shorten the period of supply anyway, because they do not have sufficient stock or secure storage capacity
- pharmacies increasingly becoming targets for robberies, with danger to people and property

Regards,
Kirsten Simonsen
RegPharmNZ

From: Pauline McQuoid <s 9(2)(a)>
Sent: Wednesday, 21 December 2022 12:30 pm
To: Consult
Subject: Misuse of Drugs amendment regulations consultation

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Hi,
I am a pharmacist prescriber working in primary care in the Bay of Plenty. I also review medication for people with chronic pain under ACC Pain Management programme. I have many years of experience in palliative care. I have also extensively researched the opioid crisis and provided many teaching sessions to doctors, nurses and pharmacists on this topic. I therefore consider myself to be very well-qualified to provide comment on the Misuse of Drugs amendment regulations.

In summary, I cautiously agree with a) legalising the electronic signature for controlled drug prescriptions (with appropriate safeguards I know that at present, using the common practice management system Medtech, I can prescribe almost anything under another prescriber's name); and b) extending the period of supply for stimulants used in the treatment of narcolepsy and ADHD (again, with the appropriate safeguards). Having said that, the current special authority criteria for methylphenidate is as big a barrier, if not more so.
I also completely disagree with extending the period of supply for other class B controlled drugs such as opioids.

I will not go into extensive detail about the opioid crisis because I assume that everyone at Pharmac knows what a major health, social and crime disaster it is. Suffice to say, they did not see this coming in the USA so we should not be complacent that it won't happen here. There are already enough issues with people being dependent on and in some cases addicted to opioids for "chronic pain". I am talking about non-malignant pain, not cancer pain. Chronic non-malignant pain (CNMP) is poorly responsive to medications, including opioids. There is a substantial body of evidence supporting this, as well as evidence that early administration of opioids for people with acute injuries is associated with a higher proportion of people being off work after one year (after controlling for variables). However, people are started on these medicines in hospital and they expect their GP to continue them. One of the dangerous factors about opioids for CNMP is that there is no upper dose limit, so when they don't provide good pain relief ie most of the time, instead of stopping or changing to another medicine, the dose is increased. Doctors are used to prescribing for palliative cancer pain and unfortunately they apply the same principles to CNMP, which is completely different. In one of my medical practices, the doctors have asked me to review and manage their patients on opioids and try to get their doses down. I have combed through their medical records in detail and I have come across numerous examples of the pressure that many of these people exert on their doctors for opioid prescriptions before they are due, prescriptions to replace "lost" or "stolen" opioids (and benzodiazepines), dose increases, etc etc. These are not even opioid substitution patients, they are chronic pain patients. At least with monthly prescriptions and ten day dispensings, we can ensure that there are not large quantities of opioids circulating in the community but the new regulations will remove this safeguard.
Another problem I commonly see is that patients will increase their doses themselves, then when they see the doctor they say they need the higher dose. I can't count the number of people who have ended up on inappropriately high doses of opioids this way. They put pressure on the doctor to increase the dose, saying that it is what they have been using and what they need. It will be much harder to monitor and manage doses with a longer period of supply.

Please don't increase the period of supply for opioids. It is hard enough for us to manage this in primary care already. Changing to electronic signature will be helpful, but extending the period of supply will have far-reaching consequences. Please don't let this go down in the history books as one of the steps towards NZ's own opioid crisis.

Kind regards,

Pauline McQuoid
Clinical Pharmacist
Medwise
Office phone: (07) 218 6337
Mobile phone: s 9(2)(a)
Email: s 9(2)(a)
Office fax: (07) 579 4222

From: Tracey Borrie <s 9(2)(a)>
Sent: Wednesday, 21 December 2022 10:10 am
To: Consult
Cc: Katie Brown; Kathryn Henshaw
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs
Attachments: Submission to Pharmac re Changes to Class B Controlled Drugs Funding.pdf

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Mōrena,

Please find attached our submission regarding your proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs.

Kind regards
Tracey

Tracey Borrie (she/her) | BPharm PGDipClinPharm
Clinical Facilitator | Kaiwhakahaere Rongoā (Rata)
Clinical Quality & Education Team, Pegasus Health (Charitable) Ltd.

Nāu te rourou, nāku te rourou ka ora ai te tangata
With your contribution and my contribution we will nourish the people

(Working: Thursdays and Fridays 8 - 430 pm)

Class B Controlled Drugs Consultation
Pharmac
consult@pharmac.govt.nz

Pegasus House
401 Madras Street
PO Box 741, Christchurch 8140

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www.pegasus.health.nz
info@pegasus.org.nz

21/12/2022

Dear Sir/Madam,

Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs, dated 28 November 2022

Please accept this submission from Pegasus Health. Pegasus Health (Charitable) Ltd is a large primary health care organisation in Canterbury with around 445,000 people enrolled in its general practice services, representing most of the Canterbury population.

Pegasus Health is committed to providing safe and effective patient care, and while we are generally supportive of increasing access to care including medicines, there are some areas of concern and consideration for the current proposal around class B controlled drug dispensing and funding outlined below:

- **Issues for patients**

Increased quantities in patient homes may lead to:

  - An increase in misuse, including dose escalations, overdoses, and diversion. The National Poisons Centre receive a significant number of calls each year regarding opioid exposure, and a significant number of deaths occur annually (see **link, p9 & 10**). NZ Coroner's data indicates an increase in overdose cases over the last 5 years, particularly with opioids (see **link**).
  - Increased security concerns, not just from burglaries but stealing may occur by family or carers. Concern may exist particularly for patients known to be likely on opioids, such as patients with cancer or who are palliative.
  - Exacerbate issues with inappropriate quantities of 'PRN' class B opioids in patient homes. 'Prn' prescribing without a specified quantity results in the maximum quantity getting dispensed, which may equate to a large amount of unneeded drug over a 3-month period. E.g., morphine 20 mg BD +10 mg Q4H prn would result in 540 x 10 mg tablets over the 3 months. This is not only a patient safety issue but also contributes to medicine waste.

- **Issues for supply from pharmacies**

  - Lack of CD safe storage space, which is already an issue for a number of pharmacies and facilities and is expected to worsen when tramadol changes to Class C2 in October 2023. Recent changes to codeine packaging (bottle to bulkier blister packs) also contribute to this

problem. Pharmacies may not have room to add more CD cupboards, and may have to part-dispense the prescription and 'owe' the patient, or they may not have sufficient space to carry stock in advance of the patient visit resulting in further delays to patient access to medications

- Costs incurred to increase CD safe capacity in pharmacies (if they have sufficient space to add another safe)
- Potential for an increase in security risk, e.g., armed hold ups, since pharmacies will be known for holding significantly more stock. This risk may extend to other areas of the supply chain (wholesalers, distribution/couriers)

Potential ways to mitigate these issues may include:

- Monitoring of Class B opioid usage before and after the funding changes.
- Considering education, to highlight:
  - the lack of evidence for use of opioids in non-cancer pain
  - evidence of harm from opioids, including overdoses and death
  - a reminder that shorter dispensing periods may be preferable for some patients
  - a refresher on detecting drug seeking behaviour could be considered
  - ensure prescriber states quantity of opioid to be dispensed for 'prn' prescribing
  - encourage patients to return supply no longer required.
- Amendments to allow class C opioids (codeine and tramadol) to be safely stored outside of the safe within the pharmacy to ensure that sufficient class B controlled drugs can be stocked for regular patients (risk minimization and mitigation).
- Ensure pharmacies can be part of the decision-making process on dispensing frequency without an increase in paperwork, for example when deemed in the best interest of the patient and community e.g., patient doesn't have safe storage at home or is worried about stealing, patient may be palliative and on syringe driver with changing doses and risk of significant waste.

We thank you for the opportunity to provide feedback.

Kind regards,

Tracey Borrie

On behalf of: Clinical Quality and Education, Pegasus Health (Charitable) Ltd

Email: CQEAdmin@pegasus.org.nz

From: s 9(2)(a) <s 9(2)(a)>
Sent: Thursday, 22 December 2022 8:10 am
To: Consult
Subject: Class B controlled drugs

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Sent from my Galaxy

Good morning,
I am a semi retired pharmacist and while I can understand the reasons why the proposal to be able to supply class B controlled drugs in larger quantities has come about, I am opposed.

Reasons why this will cause problems.
There will be much larger quantities of class B drugs being prescribed.
This will mean increased costs for pharmacies because of volumes required to be kept in an appropriate safe. (if the pharmacist decides they need sufficient stock for say 3 prescriptions of a medication on hand then you have tripled the stock holding. Multiply that by several drugs and all the strengths then additional space will be required)
As a locum pharmacist I see a lot of dispensaries where the safes are at capacity now so will the owners do a refit of the dispensary to accommodate a new safe or will they " make do"?

I have been the victim of a armed holdup by someone looking for class B drugs.
By increasing the amount required to be on the premises, you are increasing the risk to staff.

You will be greatly increasing the volume of these drugs in the residential area.
[redacted]
Your proposal would increase the volume of these.

As a responsible pharmacist, I encourage patients to return any medication that is no longer required, especially class B drugs.

When these are returned to a pharmacy, there is a procedure that must be followed before they can be destroyed. It involves 2 pharmacists and can be very time consuming. If there is only 1 pharmacist present, the medications must be stored appropriately until there is a 2nd pharmacist, with time , is present. This puts more pressure on space in the safe.

Unlike others medication, class B controlled drugs can't be disposed of in the normal way, nor can they be sent to medical aid aboard. This means the only effective way is to flush them down the waste water system, which has an additional impact on the environment.

For these reasons, I would like the normal supply of class B controlled drugs to remain at 10 days per dispensing. The cost savings for the government in dispensing fees will be passed on to pharmacies in increased costs, and while it can be argued that it means the patient doesn't have to visit a pharmacy as often thereby increasing access, I do not know many people who buy a months worth of groceries. I would put it to you that most people visit a grocery store/supermarket at least once a week.

Yours sincerely

s 9(2)(a)

From: Garry [redacted] Brown <[redacted]>
Sent: Thursday, 22 December 2022 7:23 am
To: Consult
Subject: feedback on proposed CD supply changes

[You don't often get email from [redacted]. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification]

Good morning

belatedly and in haste, as a community pharmacist

thank you for delaying/revisiting this issue (v busy time of year to produce feedback)

I signal my random thoughts re increased supply of CD's

I support amendment of CD scripts to allow full e-prescribing and for 3/12 (useful admin wise and GP consult time demands)

I do not support amendment of period of supply rules at pharmacy , because

burden on pharmacy

(costs to upgrade/add extra safes - just dropped 5K on a new safe and it won't be big enough because of the packaging changes and increased volume required to store the new foil packed cardboard box codeine. That's before the proposed amendment)

compliance monitoring (abuse/overuse monitoring) compromised by increased supply in pt hands patient risk (more attractive needs in homes = more standover, higher burglary risk, higher OD risk, more concern expressed by patients) where excessive use occurs having more on hand for the pt can = more temptation and more " creep " re pickup dates. Anecdotally, we see this with already with 1/12 supply methylphenidate where GP's seem unaware of increased usage - where we see a month supply script regularly ordered/filled in 20 day periods (supply legal by usage rules but unwise as feeding a bad habit ; yes, we provide specific management feedback to the prescribers)

increased wastage (see it now with big volumes of injectables ordered for pumps, only to be returned to the pharmacy a few days later as pt deceases or moves to hospice care)

we already monitor our CD pts closely;- we're rural and work v hard to ensure, for example, a 10 days supply doesn't fall due on a Sunday (a non-opening day for us)

increased risk to pharmacy (in my career I've had 2x aggravated robberies, both focused on content of our CD safe - that's 2 too many)

Incompletely and in haste

From: Brenda Buck <s 9(2)(a)>
Sent: Monday, 28 November 2022 1:47 pm
To: Consult

You don't often get email from s 9(2)(a) Learn why this is important

As a pharmacist I am concerned about the new changes to the changes of dispensing of class B controlled drugs.

Why are you rushing through with this and hardly allowing any time for feedback.
Do you even take into consideration that our script volume increases at this time of year and we are already rushed off out feet.

These have all already been brought to your attention , but I feel and am concerned about the same issues.

You may wish to consider.

1. Patient safety issues - unused medicines, high volume, frequent changing doses

2. Safety of staff and community pharmacies needing to store more CDs

3. Lack of CD safes in NZ - is this actually implementable in the first place ?

4. Risk of out of stocks within the pharmacy causing patient delays to access - most would need to order in to dispense rather than hold in stock

5. Environmental nightmare hazard with wastage

6. Poor prescribing of CDs that cater for appropriate volumes over time

7. Timing and need for more consultation as lots of unintended consequences/risks that need to be measured

8. No national system for identifying drug seekers still... higher risk with higher volume supply

Kind regards
BRENDA BUCK
s 9(2)(a)

From: Bronwen Shepherd - Green Cross Health <s 9(2)(a)>
Sent: Monday, 28 November 2022 10:49 am
To: Consult
Subject: Pharmac Consultation regarding proposed changes to the Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs.

You don't often get email from s 9(2)(a) Learn why this is important

RE Pharmac Consultation regarding proposed changes to the Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs.

HI team
I have many concerns regarding proposed changes to pharmac rules on dispensing class B drugs which open up supply for 30 days supply instead of 10 days supply

I understand pharmac are required to consult and consider broader concerns that may sit outside their remit.

1. The largest concern is for the safety of community pharmacy needing to store at any one day up to 3 x the volume of CD Medicines. This is a significant safety concern given ram raids and hold ups increasing in number across the motu.

2. 2nd issue is patient and whanau safety, given the large volume of doses given to individual patients - often during terminal illness. Pharmac must first do an analysis on cd volumes and unused returns to understand the problem

3. Practicalities of storage, if pharmac aware for example that there are currently no large Cd safes in Nz for purchase and there is a world wide shortage.

4. Large supply on scripts with no safe or available storage will lead to massive number of daily orders, and "owes to patients" as pharmacies will not be able to fulfill all orders. When the system is at a stretch already this adds to inefficiency. From a patient perspective they will need to wait 1-3 days per prescription which is also not great for health outcomes.

5. Environmental waste is already a hazard and antibiotics and CDs hold the highest risk to our environment. There is no current analysis of drug destruction in nz including of CDs and the extra work they require to safely dispose. The move to stat dispensing

for other medicines caused a 3 fold increase in drug wastage. This is untenable in today environmental crisis.

The consultation prior to Xmas on this is an insult to a profession that has worked so hard to maintain safe medicine supply to aoteraoa. This initiative needs a lot more consideration and consultation..

Thank you

Bronwen Shepherd BPharm MPS
Senior Regional Manager
Care in the Community Clinical Lead
Green Cross Health, Wellington

s 9(2)(a)

Support Office Physical Address | Millennium Centre, Ground Floor, Building B |602 Great South Road | Ellerslie | Auckland

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From: Redcliffs Pharmacy <dispensary@redcliffspharmacy.co.nz>
Sent: Monday, 28 November 2022 4:44 pm
To: Consult
Cc: redcliffspharmacy.co.nz
Subject: Consultation on Controlled Drugs

Kia ora

As pharmacists we welcome the changes to the legislation regarding the prescriptions and supply periods for controlled drugs.

We disagree with the proposal to change the period of supply of Class B Controlled Drugs from 10 days to 30 days for the following reasons:

- Storage – more storage space (larger safes) will be required. This represents a sizable capital outlay for most pharmacies and may challenge space restrictions already present in the pharmacy
- Patient safety – there will be larger quantities of these medications in the community which may not be correctly stored or destroyed in a timely manner, with the risk of inappropriate use (e.g by the right patient, or their whanau, for the wrong condition)
- Misuse – larger quantities in the community may feed the supply for people who misuse these drugs, and increase targets for burglaries.

Regards

Daryl Sayer
Pharmacist
Christchurch

From: Gail Cowles <[redacted]>
Sent: Monday, 28 November 2022 4:12 pm
To: Consult
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

You don't often get email from [redacted] Learn why this is important

Thank you for the opportunity to provide feedback.

I do NOT support this proposal, with the exception of stimulants (methylphenidate, dexamfetamine) which are used for a chronic condition (ADHD, narcolepsy). Allowing 3 monthly scripts makes complete sense for a chronic condition and will reduce the burden on carers, patients and busy GPs.

I am concerned that if this proposal goes through, there will be inadvertent overprescribing of narcotics and it could reverse all the hard work that has gone into changing prescribing habits around the use of opioids for non-cancer chronic pain. For this reason I do not see any benefit in this proposed change.

Allowing collection of a 1 month supply of morphine, fentanyl etc will result in increased cost of medication, increased waste, & potentially increased risk if unused supplies are not disposed of correctly or are diverted. NZ does not need to do anything more to risk our own homegrown opioid epidemic or widespread fentanyl mis-use as seen in other jurisdictions.

Gail Cowles
Clinical Pharmacist

From: Hannah Buckley <s 9(2)(a)>
Sent: Monday, 28 November 2022 3:04 pm
To: Consult
Subject: Dispensing of Class B controlled drugs - feedback from Pharmacist

[You don't often get email from s 9(2)(a). Learn why this is important at https://aka.ms/LearnAboutSenderIdentification]

Hi there,

Thanks for taking feedback from pharmacists on this matter. A number of issues arise here:

- CD safe capacity - we have the largest CD safe available - we will need to install a second to be able to accomodate monthly allocations of stock for our customer base. There will probably need to be a larger option available - but this will cost the pharmacy business to purchase at what will be a greater cost. The number of CDs prescribed has increased dramatically since i qualified (eg a small CD register used to last 1 year, now we would be lucky if it lasted 3 months)

- Returns - as a sole charge pharmacy (apart from occasional days) we have to store CDs returned for destruction until 2 pharmacists are on duty to witness the destruction. This process takes us approx. 2 hours a week at the moment (to write all in, out and destroy) - a service we do not get funded for might I add. There is already a huge amount of waste - morphine, fentanyl etc are largely for palliative care & have huge amounts of dose changes. The returns we get are people doing the right thing and returning them to us, what about those that do not? Is this the type of medication you want circulating in the wrong areas & in larger numbers??

- Safety - I fear that if word gets out that we have larger amounts of controlled drugs on site to be able to service these prescriptions that it puts my business, staff & self at risk. Pharmacy has not been in the spotlight / the target of break ins more recently & it would be nice to keep it this way.
Safety also applies to the patient who is given 1 month supply of morphine for example - do we want to see our elderly targeted for their controlled drugs? With some clients off the top of my head to receive up to 160-200 morphine capsules at a time is unsafe if getting into the wrong hands (carers taking advantage (this is happening), family members, childen etc.).

- Ethics/addiction - 10 day allocation is easy to manage those who are increasing doses without communication with their GPs, month supplies will not be. I already see issues with those taking too much medication / going through it far too quickly having 1 month supply in a single go. This will lead to downstream management by us needing to liase with their GPs. How can ethically this be safe? Yet on the other hand purchasing a bottle of pholcodine OTC be unsafe? It makes no sense.

- More new rules for us to train medical centre staff on - GPs are only just getting used to the existing eprescription rules. Its been a busy year with professional burnout on a number of levels, December being busier than ever & we will have new rules and systems to overcome.

I do not think all of these matters have been thought through & I am sure my colleagues agree if they have the time to take from their busy dispensaries to be able to offer feedback.

Much appreciated if you could take note of these and reconsider the proposition.

Kind regards,

Hannah Buckley
Pharmacist - Hawkes Bay

Sent from my iPhone

From: Ian Hutchinson <ptchevpharm@xtra.co.nz>
Sent: Monday, 28 November 2022 9:12 am
To: Consult
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

Hello,

I fully support the proposed changes for dispensing of class B controlled drugs and don't envisage any problems with implementation, the current rules are at times unworkable especially when painkillers are prescribed PRN and patients with apparent repeats by a certain date are denied supply because they haven't picked up available repeats frequently enough.

Ngā mihi
Ian Hutchinson
Unichem Point Chevalier Pharmacy
1213 Great North Road
Point Chevalier
Auckland 1022
Phone 09 846 1676
Fax 09 815 2206

From: James Westbury <s 9(2)(a)>
Sent: Monday, 28 November 2022 1:59 pm
To: Consult; Pharmacy Guild, Andrew Gaudin
Subject: C D consultation

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To Whom It May Concern

As a pharmacy owner I am very concered about the changes.

Holding more stock presents a significant security risk for staff given the issue with dairys facing armed hold ups. I am concerned criminals will start turning to pharmacies.

The storage requirements will be significant to hold one months worth of stock.

I am very conerned about the increase in narcotics in the community with this change and tje potential for abuse. This approach seems at odds with other changes re cough medicines being reclassified business staff safety etc. Seem one organisation behaves in a different dashion to the other.

I would request that current dispensing frequencies remain but the prescription is valid for 3 months.

Kind regards

James

Get Outlook for Android

From: Karen Ng <s 9(2)(a)>
Sent: Monday, 28 November 2022 5:26 pm
To: Consult
Subject: Consultation on Class B controlled drugs

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Pharmac Consultation Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs - Pharmac | New Zealand Government

Dear Pharmac,

I have worked in community pharmacy since 2006, originally in Auckland and now Hawkes Bay. As a pharmacist, the proposal opening it up for EVERYONE presents a multitude of problems in actual practice, and I would strongly recommend this should NOT be done.

While I understand there are chronic pain patients that remain on a stable treatment plan, the default dispensing quantity should not change.

Perhaps instead there is room for a Special Authority permission to open a small gap for 3 monthly-prescribing ***only for named patients*** deemed stable enough for long term supply by GPs AND Pharmacists.

The proposed change would create even more issues which I will expand on below:

Limited Storage in Controlled Drug Safes in Community Pharmacy.

- Controlled Drug safes are small and limited in capacity in Community Pharmacies.
- We just don't have the space to store so much quantity to fill monthly lots for everyone. For high volume pharmacies that fill 400-600 prescriptions a day or more, this is an unrealistic quantity to keep.

Ram Raids and Safety:

- We have all seen the devastating harm of ram raids on local businesses in our communities.
- Having to keep 3x the quantity of controlled drugs on premises presents a larger risk to our safety of staff, and possibly deadly burglary attempts by drug seekers.
- We already have so many pharmacists leaving the profession, are we really wanting to make it even less desirable to work in community pharmacy?

Medicines Wastage - An environmental nightmare

- Giving patients a default 1 month is excessive in many cases.
- We already hear of patients selling their amphetamines and morphine on the black market.
- Often if the patient dies, it is us that has to bear the time and cost of disposing of their stockpile of drugs, furthering an environmental nightmare of medicine waste.

Patient Safety:

- With many prescribers changing doses in 1 or 2 weeks, or changes with entry and discharge from hospital, we see a risk of patients having a surplus at home of different strengths and formulations.
- This causes an even greater risk of patients overdosing if there is even a minor miscommunication in their medicine change.
- Not only that, if dodgy neighbours know their elderly neighbour has a stockpiles of controlled drugs at home, they may be at risk of a home invasion or burglary.
- We often tell patients/caregivers to return unused medicine but many of them don't until the patient passes away.

Business Viability & Stock Issues

- With a greater demand for a higher level of stock to be held pharmacies bear the cost of holding 30 days of stock rather than 10 days of stock which is much more manageable with cash flow.
- Furthermore, we already see the out of stock issues that delays patient access to medicines for possibly months on end.
- There are already so many stock issues with global supply interruptions, having to order and supply larger amounts of Controlled Drugs will just add to the problem.
- Cutting out pharmacy dispensing fees mean we are again hit with more work (to counsel and manage patients medicine) but less pay.
- See this 2003 article about STAT bulk dispensing and the huge financial hit pharmacies have taken. We currently give free advice, translate health information for patients and more and more of us will have to close under the pressure of less income, but more cost.
- Many of our younger pharmacists have left the country or left the profession as business is harder and harder while the demands are greater and greater.
- Where are the GP's during the pandemic? They work behind closed doors, not accessible face to face, only via Zoom which many of our elderly patients struggle with.

Crime / Drug Seekers

- There is still no National System of identifying drug seekers. This should be of prime importance BEFORE enabling more drug use and abuse.
- The excessive use of controlled drugs should not be further encouraged with larger quantities widely available to patients that don't need them.
- We have drug seekers that shop around and only those of us that locum catch them "trying their luck" at multiple shops getting their prescriptions from multiple prescribers. And even when they're caught, not much happens.

- We just heard about the woman who stole a prescribing pad and went on a spree with forged scripts, obtaining over 300 pills. She gets home detention for 6 months, but the three pharmacies she targeted gets disciplined. The excess pills she obtained, she "shared with friends".

GP Accountability & Prescribing Software Updates:

- We have ongoing issues with patients wanting early repeats dispensed, the GP's complacency of allowing early release was only slowed down once multiple pharmacists querying the excessive supply.
- Currently the large majority of prescribers we have need to be reminded to SIGN their CD scripts to be dispensed, even with the ePrescription rules. This took ages and most of them didn't know it was still a requirement for CDs on e-prescriptions.
- When GP's are allowed to ignore the legislation and send through whatever, pharmacists bear the brunt of reminding and chasing up prescribers to sign their CD scripts!
- While we are diligently updating our software once a month with all the Pharmac updates, GP's are still prescribing medicines that were long delisted or discontinued, or with dosing / quantities that are mismatched.
- There should be much stricter rules for GP's having to update their software so there are less mistakes and errors to align with pharmac rules and meds regulations.

Until you fix all those issues you should not be changing the current legislation. 7 day or 10 day lots is sufficient for Controlled Drugs to be managed.

The default should still be 7 day or 10 day lots. If there is a place for chronic cancer patients or chronic pain patients to have more, then that could be a special authority number or special order permission for the dispensary to give for that NAMED patient.

Please don't make our jobs and businesses harder when pharmacists are harder and harder to find.

Thank you

Karen Ng

Pharmacist

From: Milton Pharmacy <mail@miltonpharmacy.co.nz>
Sent: Monday, 28 November 2022 10:50 am
To: Consult
Subject: CD's

[You don't often get email from mail@miltonpharmacy.co.nz. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification]

Hi

Just a query regarding the proposed changes to CD rules.
Is there any change proposed to how long a class B CD script is valid for, ie will it still be only 7 days from writing or has this been inbcreased?

Regards
Chris London
Milton Pharmacy

From: Tamsin Willis <s 9(2)(a)>
Sent: Monday, 28 November 2022 2:30 pm
To: Consult
Subject: FW: Pharmac consultation: proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

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Hi Pharmac

Re: Amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

I appreciate these changes predominantly affect GP prescriptions to community pharmacies however I would like to feedback on the difficulties we are having running effectively 2 systems – electronic and paper based.

In hospital we are not integrated with NZePS and no way to read barcodes, so cannot dispense barcoded CD prescriptions.
However we receive prescriptions from GPs, ARC doctors and hospice for initiating IV controlled drugs until community pharmacies can order supply in.
GP's inform us there are no paperbased CD triplicate prescriptions anymore, they are all electronic.

How do we supply controlled drugs when there is no legal prescription?
It seems a waste of time to chase the doctor to send a triplicate prescription – we essentially have to post one of ours out to cover the dispensing in retrospect, and wait for them to send it back.

I feel these changes are coming into effect before the electronic systems are in place.

Thanks

Tamsin Willis
Pharmacist – Medication Safety and Quality Coordinator |
Pharmacy Department and Health Quality & Safety Service

Hauora a Toi Ba of Plent
waea pūkoro: + s 9(2)(a) | s 9(2)(a) | **īmēra:** s 9(2)(a)
Pharmacy Department, Tauranga Hospital | Private Bag 12024, Tauranga 3143

Te Whatu Ora
Health New Zealand

Te Whatu Ora – Health New Zealand
TeWhatuOra.govt.nz

From: Te Pātaka Whaioranga - Pharmac <consult@pharmac.govt.nz>
Sent: Monday, 28 November 2022 9:00 am
To: Karen Street <s 9(2)(a)>
Subject: Pharmac consultation: proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

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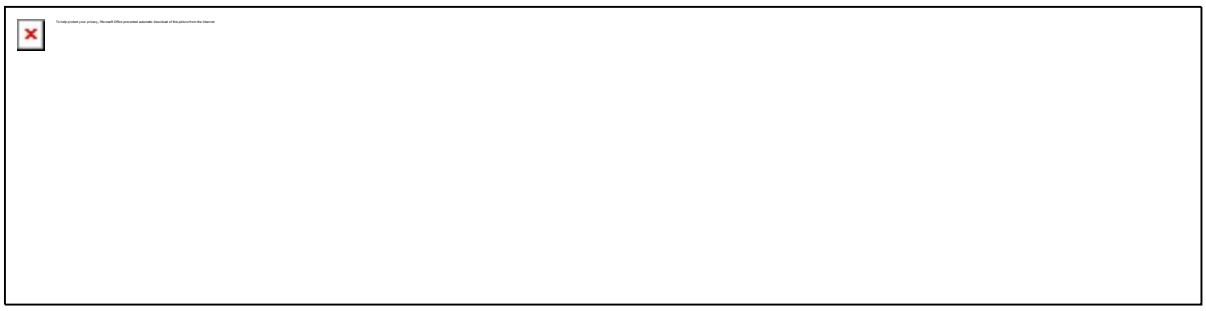


Pharmac consultation: proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

Kia ora

Please follow this link to the Pharmac Consultation regarding proposed changes to the Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs.

Pharmac welcomes feedback on this proposal.

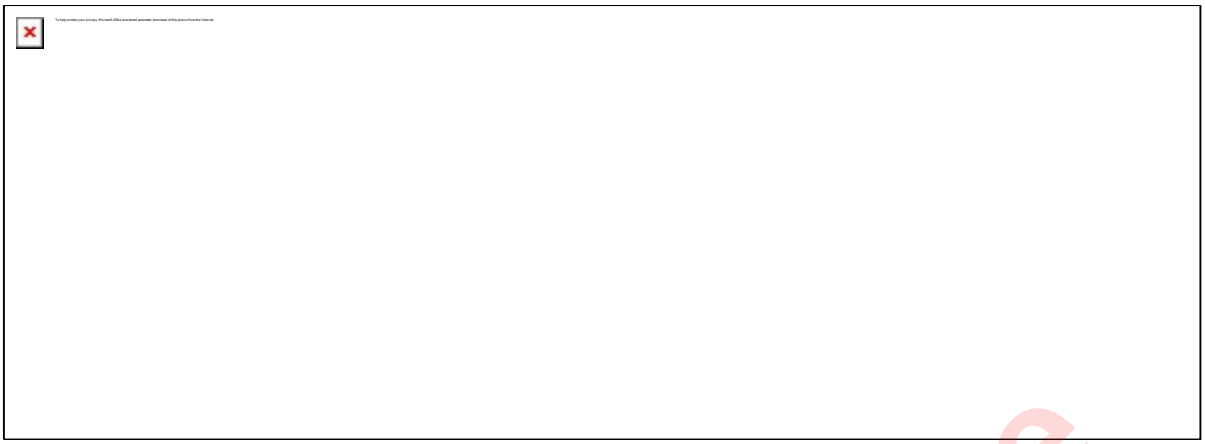
To provide feedback, please email consult@pharmac.govt.nz by **5pm on Friday 9 December 2022**.

Please circulate this email to others who may be interested.

Ngā mihi,

Belinda Ray-Johnson | Schedule Development Manager

Pharmac | Te Pātaka Whaioranga | PO Box 10 254 | Level 9, 40 Mercer Street, Wellington | P: 0800 660 050 | www.pharmac.govt.nz



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From: Te Puna Pharmacy <dispensary@tepunapharmacy.co.nz>
Sent: Monday, 28 November 2022 9:51 am
To: Consult
Subject: Consultation feedback: Class B Controlled Drugs

Hi there,

The decision to increase total quantity of supply of methylphenidate and dexamfetamine is very good, and will be of huge benefit to a large number of well-controlled patients with ADHD etc.

However, supplying a full month's worth of CDs, especially painkillers, is not a good idea. If a medicine is deemed dangerous enough to be classed as Class B then it obviously has safety concerns associated with it, so larger quantities have larger safety concerns. Also, a large number of patients prescribed these medicines are in the last stage of their life, so wastage would also significantly increase

Ollie

Te Puna Pharmacy
2C/4 Te Puna Road
Te Puna
Tauranga 3174
Phone 07 262 2170
Web: www.tepunapharmacy.co.nz

From: s 9(2)(a) <s 9(2)(a)>
Sent: Monday, 28 November 2022 3:28 pm
To: Consult
Subject: Feedback: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

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I request my feedback treated as confidential

I am a community pharmacist and I do not agree with the proposal as it currently stands for a number of reasons;

- storage of this volume of controlled drugs would not be possible with the existing space in our safe and due to the size of the dispensary a larger safe is not able to be installed

- safety concerns for staff due to increased volumes of controlled drugs stored on site- particularly with an increasing climate of theft and aggravated robbery

- increased likeliness of medicine wasteage (i.e. dispensing one month's worth of sevredol when the patient only ends up taking for a few days)

- for patients with mobility issues pharmacists are already able to access exemption and provide the full one months supply in the cases where they deem this to be in the patients best interest and safe to do so. Most doctor's consults are also done via phone so people are not having to come in for an appointment every month already.

- There has not been enough time allowed (with proposed implementation on 1/2/23) to allow pharmacies to prepare for this change (controlled drug safe's are in shortage and difficult to organise trades to update dispensary design over the christmas period)

From: Ben Araba <mountainviewpharmacy@hotmail.com>
Sent: Tuesday, 29 November 2022 2:06 pm
To: Consult
Subject: Proposed Changes to Controlled Drug Laws

Good afternoon,

We are emailing from Mountainview Pharmacy in Hawera.

We have read the proposal and don't agree with the changes.

Coming from a small rural community there is risk to not only the patients but to the community as a whole. With higher quantities of controlled drugs in the community there is a higher risk of sales as well as over dose both of which we have seen here.

Also, the proposed changes create a lot more work for the pharmacy staff because we will be the ones who will have to ring the doctors everyday when patient's want the medications early.

Overall, the changes would create more risk to patient's and the community, more work for pharmacy staff, more wastage on controlled drugs, over use of controlled drugs, problems with early dispensing of controlled drugs, and more stress to pharmacy staff

Please reconsider the changes to controlled drug dispensing.

From: Garth Mitchinson <s 9(2)(a)>
Sent: Tuesday, 29 November 2022 9:38 am
To: Consult
Subject: Prescribing and Dispensing of Class B Drugs

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Whilst this proposal does have some merit, there are far too many negatives to it that may have not been considered fully.

Allowing a three month prescription in chronic patients on stable pain relief makes perfect sense. Giving out a month at a time is not quite such a logical next step. Large quantities of CDs kept on site are a security risk for both Pharmacies and Patients, and an uptick in burglaries is a logical extension once this becomes common knowledge. Whilst we have a safe (that will also need replacing, as even now we can barely fit all our CDs in), patients do not have this. Exposing vulnerable patients to an increased risk of this does not justify the benefits. This would be need to be explained to patients by Doctors if they were prescribing large amounts of CDs, as it would potentially lead to more harm than good.

We also have a significant number of CD prescriptions that are for people that do not even use the supply we currently give them, be it for acute pain, or terminal care. We often get large quantities of CDs returned to us, and the potential harm if any of these medicines were not returned with the increased quantities given, is quite frightening.

I support increasing the prescriptions to 3 months supply, but not the increase to dispense one month of medicine at a time.

Sincerely

Garth Mitchinson
Life Pharmacy Tauranga

Sent from Mail for Windows

From: Leanne Short <s 9(2)(a)>
Sent: Tuesday, 29 November 2022 1:48 pm
To: Consult
Subject: Consultation on Class B controlled drugs

You don't often get email from s 9(2)(a) Learn why this is important

Pharmac Consultation Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs - Pharmac | New Zealand Government

Dear Pharmac,

As a pharmacist, the proposal opening it up for EVERYONE presents a multitude of problems in actual practice, and I would strongly recommend this should NOT be done.

While I understand there are chronic pain patients that remain on a stable treatment plan, the default dispensing quantity should not change.

Perhaps instead there is room for a Special Authority permission to open a small gap for 3 monthly-prescribing ***only for named patients*** deemed stable enough for long term supply by GPs AND Pharmacists.

The proposed change would create even more issues which I will expand on below:

Limited Storage in Controlled Drug Safes in Community Pharmacy.

- Controlled Drug safes are small and limited in capacity in Community Pharmacies.
- There is not space to store monthly quantities for everyone. For high volume pharmacies that fill 400-600 prescriptions a day or more, this is an unrealistic (AND UNSAFE!!) quantity to keep.

Ram Raids and Safety:

- We have all seen the devastating harm of ram raids on local businesses in our communities.
- Having to keep 3x the quantity of controlled drugs on premises presents a larger risk to our safety of staff, and possibly deadly burglary attempts by drug seekers.
- We already have so many pharmacists leaving the profession, are we really wanting to make it even less desirable to work in community pharmacy?

- In my own community I have had my wine shop manager held up at gunpoint at 3.30pm in the afternoon while kids walked past outside after school - for a measley $400 or less. Not to mention the murder of dairy owner in a nearby suburb this week. Horrific.

Medicines Wastage - An environmental nightmare

- Giving patients a default 1 month is excessive in many cases.
- We already hear of patients selling their amphetamines and opiates on the black market. Do we want to encourage this? Do we want to see more homebake heroin across NZ?
- Often if the patient dies, it is us that has to bear the time and cost of disposing of their stockpile of drugs, furthering an environmental nightmare of medicine waste.

Patient Safety:

- With many prescribers changing doses in 1 or 2 weeks, or changes with entry and discharge from hospital, we see a risk of patients having a surplus at home of different strengths and formulations.
- This causes an even greater risk of patients overdosing if there is even a minor miscommunication in their medicine change.
- Not only that, if dodgy neighbours know their elderly neighbour has a stockpile of controlled drugs at home, they may be at risk of a home invasion or burglary.
- We often tell patients/caregivers to return unused medicine but many of them don't until the patient passes away.

Business Viability & Stock Issues

- With a greater demand for a higher level of stock to be held pharmacies bear the cost of holding 30 days of stock rather than 10 days of stock which is much more manageable with cash flow.
- Furthermore, we already see the out of stock issues that delays patient access to medicines for possibly months on end.
- There are already so many stock issues with global supply interruptions, having to order and supply larger amounts of Controlled Drugs will just add to the problem.
- Cutting out pharmacy dispensing fees mean we are again hit with more work (to counsel and manage patients medicine) but less pay.
- See this 2003 article about STAT bulk dispensing and the huge financial hit pharmacies have taken. We currently give free advice, translate health information for patients and more and more of us will have to close under the pressure of less income, but more cost.
- Many of our younger pharmacists have left the country or left the profession as business is harder and harder while the demands are greater and greater.
- Where are the GP's during the pandemic? They work behind closed doors, not accessible face to face, only via Zoom which many of our elderly patients struggle with.

Crime / Drug Seekers

- There is still no National System of identifying drug seekers. This should be of prime importance BEFORE enabling more drug use and abuse.
- The excessive use of controlled drugs should not be further encouraged with larger quantities widely available to patients that don't need them.
- We have drug seekers that shop around and only those of us that locum catch them "trying their luck" at multiple shops getting their prescriptions from multiple prescribers. And even when they're caught, not much happens.

- We just heard about the woman who stole a prescribing pad and went on a spree with forged scripts, obtaining over 300 pills. She gets home detention for 6 months, but the three pharmacies she targeted gets disciplined. The excess pills she obtained, she "shared with friends".

GP Accountability & Prescribing Software Updates:

- We have ongoing issues with patients wanting early repeats dispensed, the GP's complacency of allowing early release was only slowed down once multiple pharmacists querying the excessive supply.
- Currently the large majority of prescribers we have need to be reminded to SIGN their CD scripts to be dispensed, even with the ePrescription rules. This took ages and most of them didn't know it was still a requirement for CDs on e-prescriptions.
- When GP's are allowed to ignore the legislation and send through whatever, pharmacists bear the brunt of reminding and chasing up prescribers to sign their CD scripts!
- While we are diligently updating our software once a month with all the Pharmac updates, GP's are still prescribing medicines that were long delisted or discontinued, or with dosing / quantities that are mismatched.
- There should be much stricter rules for GP's having to update their software so there are less mistakes and errors to align with pharmac rules and meds regulations.

Until you fix all those issues you should not be changing the current legislation. 7 day or 10 day lots is sufficient for Controlled Drugs to be managed.

The default should still be 7 day or 10 day supply at one time. If there is a place for chronic cancer patients or chronic pain patients to have more, then that could be a special authority number or special order permission for the dispensary to give for that NAMED patient...and there should be additional precautions in place to prevent misuse and these patients being taken advantage of by others.

Please don't make our jobs and businesses harder when pharmacists are harder and harder to find.

Ngaa mihi nui,

Leanne Short

Pharmacist

From: pburtz <s 9(2)(a)>
Sent: Tuesday, 29 November 2022 4:31 pm
To: Consult
Subject: Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs

You don't often get email from s 9(2)(a) Learn why this is important

Hi

I like the idea of dispensing in monthly quantities but as a Pharmacist have a couple of concerns.

The first one is regarding storage space required and the security risk associated with increased stock holding, this extends to the individual patient and the pharmacy and the respective wholesalers.

Another concern which I would like addressed is the return of unused controlled drug medication. Already it is a complimentary service undertaken by pharmacies which requires a lot of time and effort and documentation.

The increased dispensing quantities will compound the time undertaken to safely destroy larger quantities of unused medication.

Peter Burton
s 9(2)(a)
Timaru

Sent from Yahoo Mail on Android

From: Belinda Ray-Johnson
Sent: Tuesday, 29 November 2022 3:32 pm
To: s 9(2)(a)
Cc: Doris Chong
Subject: RE: Controlled drug changes

Kia ora Andrew

Thanks for your questions. I hope the responses below are useful.

1. The Schedule Rules (Part 10, Definitions) define a controlled drug form as below, so we don't envisage any changes to this

Controlled Drug Form means a form approved by the Director General or a form that is electronically generated from an approved system.

2. PSO/BSO forms will still be paper as we understand that the NZePS is only able to deal with individual prescriptions

Ngā mihi

Belinda Ray-Johnson

From: Andrew Shaw <s 9(2)(a)>
Sent: Tuesday, 29 November 2022 2:36 pm
To: Consult <Consult@Pharmac.govt.nz>
Subject: Controlled drug changes

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To whom it may concern,

Many thanks for sending out the consultation document – it answered most of my questions around the change.

I do still have a couple still if you're able to advise please:

1. On controlled drugs, there is a PHARMAC rule "Only on a controlled drug form" I am assuming that this will also be removed or adjusted to include wording on the NZePS alternative? Will this be amended in the NZULM information we use for our medicine file?

2. On the consultation page, it mentions that BSO/PSO supply is unaffected by these changes. Does this mean paper prescriptions are required for these supplies, or is that part pertaining to the amount that can be supplied?

Kind regards,

Andrew Shaw
Clinical Product Owner | Pharmacist, M.ClinPharm(*Dist.*), MPS

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Kind regards,

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From: David Taylor (Pharmacist) <s 9(2)(a)>
Sent: Wednesday, 30 November 2022 11:52 am
To: Consult
Subject: Consultation feedback: ivacaftor

Kia ora – in relation to "Proposal to amend Pharmaceutical Schedule Rules on prescribing and dispensing of Class B controlled drugs" I do not think it is a good idea to allow 3 monthly dispensing via electronic scripts for the following reasons:

- How do you up hold the total quantity to be supplied in words and figures using electronic prescriptions?
- Patient and public safety concerns eg pts on liquid formulations or high dose regimens would receive a high quantity of medications at once – potential for overconsumption (overdose/death) and/or makes it easier for diverting supply I know it is up to the prescriber to make adjustments to amount and they don't have to give 3 months, but I think it would be safer to leave the rule as it is to prevent error. Pts in the UK only get a month at a time of any of their regular meds (including non CDs)
- Pts may get targeted if leaving pharmacies with a large amount of controlled drugs
- Puts community pharmacy at risk as would be holding greater quantity of stock – do they even have the capacity to hold more stock (CD cupboards are usually not very large)
- Better that pts on these meds don't go a long period without seeing the GP or their pharmacist – they are a high risk population and so regular review is essential

David Taylor

Clinical Pharmacist Facilitator | Poumatuu
The Doctors Hastings/Gascoigne & Waipawa
Whānau and Communities | Te Matau a Māui Hawke's Bay

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Reach us in our local channels: ourhealthhb.nz | Facebook .com/HawkesBayDHB

Te Whatu Ora
Health New Zealand

Te Whatu Ora – Health New Zealand
TeWhatuOra.govt.nz

From: Doug Chapman <pharmacyonhand@xtra.co.nz>
Sent: Thursday, 1 December 2022 2:12 pm
To: Consult
Subject: Controlled drug consultation

Good Afternoon

I am sending you my views regarding the consultation regarding the proposed changes to controlled drug rules

Part 4 – Community Pharmaceutical Dispensing Quantities for Subsidy

4.1 Long Term Conditions (LTC) registered patients: **With the exception of prescriptions for Class B controlled drugs,** LTC patients can be dispensed to as often as the dispensing Pharmacist deems appropriate to meet that LTC patient's compliance and adherence needs.

I am struggling to find any logic to this requirement !!! As a pharmacist we are often aware of compliance and adherence issues which may not be obvious to a prescriber especially if that prescriber does not have any previous knowledge of the patient (such as locums, after hours facilities, tele health prescribers or hospital prescribers.) To be forced by Pharmac rules to dispense quantities larger than we feel safe for the patient's need, is placing pharmacists in a difficult position ethically and I think that by specifically excluding controlled drugs from the LTC dispensing frequency rules is a very dangerous decision to propose.

There are many patients who worry about their own safety when in possession of controlled drugs and by forcing patients to be in possession of even more quantities of controlled drugs then they need may be placing patients in very real dangerous situations. I predict there will be many more cases of stand over tactics, threats or intimidation or as often happens, burglaries in patients own homes.

It seems a very strange proposal that pharmacies may supply medicines to patients in weekly amounts if there are problems with hoarding, overuse or safety of medication. To be giving out a patients regular medication in weekly amounts but giving their morphine or oxycodone in monthly amounts seems dangerous in the extreme.

To assume that only the prescriber can be aware of problems with adherence, overuse or abuse of controlled drugs is an insult to Pharmacists who see patients on a far more regular basis than other Health professionals. To specifically remove pharmacists from having any input over the frequency of dispensing for these dangerous and addictive medicines to patients that we see regularly and whom we know well is sadly a reflection of the value Pharmac places on the Pharmacy profession. The only reason I can see for this proposal is to save money at the risk to patient safety and security.

I also have concerns over the amounts of controlled drugs which pharmacies are expected to carry in their safe. Once this becomes common knowledge to gangs and

criminals I can see pharmacies become an easy target for thefts as we are having in droves with dairies and jewellery stores. I have personally had three armed robberies in pharmacies I have worked in and if we are expected to carry much more stock then we do currently suggests we will be highly likely to become targets more frequently from armed offenders engaging in pharmacy robberies. We are all aware from the current spate of ram raids and dairy robberies that there is a large and active pool of potential offenders who will be all too pleased to hear of much larger amounts of controlled drugs in pharmacy safes.

Doug Chapman

Doug Chapman

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