Treating Breakthrough Cancer Pain – What Pharmacists Need to Know

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Treating Breakthrough Cancer Pain

Cancer Pain -What Pharmacists Need to Know

Accreditation:
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Target Audience:
Pharmacists: 0798
Nurses: 634

CE Credits:
Pharmacists: 0798
Nurses: N-644

Program Overview:
Cancer is one of the most common, yet misunderstood and feared symptoms of cancer. Breakthrough cancer pain when left untreated significantly impacts quality of life. The treatments available for breakthrough cancer pain options help care providers and pharmacists to provide optimal care for patients. This program introduces breakthrough cancer pain, provides healthcare professionals with an overview of the pain medications available for opioid tolerant cancer patients, and addresses the REMs process, distribution strategies, and minimize the risk of abuse and misuse of these pain medications.

Objectives:
1. Describe the etiology and epidemiology of breakthrough cancer pain in opioid tolerant cancer patients.
2. Outline the concept of opioid tolerance.
3. Review FDA approved pharmacologic treatments for opioid tolerant breakthrough cancer pain to include patient selection, pharmacologic profiles, efficacy, side effects and adverse events.
4. Describe practical strategies to mitigate the risk of overdose, abuse, addiction, and diversion and minimize medication errors to protect patients and pharmacy.

Dr. McPherson has no actual or potential conflicts of interest in relation to this program.

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Pharmacists & Nurses

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Causes of Pain in Cancer

- Pain caused by the tumor
- Pain caused by the cancer therapy
  - Diagnostic/surgical procedures
  - Chemotherapy
  - Radiation
- Pain due to chronic cancer
  - Earlier diagnosis, more aggressive treatment
  - Patients living longer with “chronic disease”
- Pain that is totally unrelated to the cancer

Cancer Pain Due to the Tumor

- Tumor invasion can cause pain secondary to a mechanical etiology
- Neurohumoral mechanisms also play a role
  - Sensitizing nerves to the mechanical effects of encroachment of the tumor on previously normal tissue
- Pathologic fracture
  - Most commonly axial spine
  - Vertebrae compression fracture or spinal instability can be a significant source of pain

Bone Pain

- The most common etiology of tumor-related pain
  - Tumor invasion of bone provokes an inflammatory response from the body that results in alterations in bone metabolism and autacoid production
  - Tumor-induced osteoclastic activity produces prostaglandins E1 and E2
    - May induce osteolysis as well as sensitize peripheral nerve endings

Neurogenic Pain

- Compression of central nervous system neurons by an expanding tumor mass
  - Produces edema, ischemia, and necrosis
  - Results in local degeneration of the axon and myelin sheath, with phagocytosis of axonal debris by macrophages
- Spinal cord compression
Cancer Pain Due to the Tumor

**Neurogenic Pain**
- Peripheral Neuropathy – Brachial Plexopathy
  - 2-5% of lung cancer patients
  - Usually C8-T1, but entire plexus may be affected
  - Presenting symptoms is pain
  - Usually a moderate to severe aching pain of the shoulder girdle that radiates along the ulnar nerve, and is aggravated by motion of the upper extremity

**Visceral Pain**
- Infiltration of solid viscera
- Tumor encroachment of vascular structures (blood/lymph)
- Tumor invasion of mucosal surfaces (lips, mouth, pharynx, GI/GU tract)
- Occurs when outlet of hollow viscera are compromised (e.g., stomach, intestine, biliary tract, ureters, bladder, uterus).
- Resulting isometric contractions and distention cause diffuse, poorly localized pain, which may be referred to dermatomes supplied by the same spinal segment.

What is breakthrough pain?

![Breakthrough Pain Diagram](http://www.fentora.com/pat210_understanding_btp.aspx)

American Pain Foundation
Background vs. Breakthrough Pain

Types of BTCP

- Incident
  - Predictable: consistent temporal causal relationship with predictable motor activity, such as movement, defecation, micturition, breathing or coughing
  - Unpredictable: inconsistent temporal causal relationship with motor activity, such as sneezing, bladder spasm, or coughing

- Idiopathic
  - Not associated with a known cause; generally of longer duration than incident pain

- End-of-dose
  - Occurring before a scheduled dose of an around-the-clock analgesic; more gradual onset and longer duration than incident or idiopathic BTP

- Pathophysiology (somatic, visceral, neuropathic)

Epidemiology and Prevalence

- No studies of cancer patients have shown prevalence < 14%
- Ranges from 19-95% of cancer patients
- International study of 1095 cancer patients:
  - 2/3 experienced breakthrough pain
- In cancer patients:
  - At time of diagnosis: 30-40%
  - During active treatment: 50-70%
  - At endstage: 70-80%

Characteristics of BTP

<table>
<thead>
<tr>
<th>Time to peak severity</th>
<th>Average</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>3-5 min</td>
<td>1-10 sec to 2 min</td>
</tr>
<tr>
<td>Moderate</td>
<td>10-15 min</td>
<td>1-3 min</td>
</tr>
<tr>
<td>Mild</td>
<td>15-30 min</td>
<td>1-5 sec</td>
</tr>
</tbody>
</table>

Consequences of BTP

- Adversely affects quality of life
  - Decreased patient functioning
  - Increased depression and anxiety
  - May predict a poorer medical outcome
  - Lower patient satisfaction with opioid therapy
- Significantly increases utilization of health care compared to patients without BTCP
- Occurs on top of a pre-existing fear of overmedication

Management of BTCP

1. General assessment (e.g., pain assessment, explanation)
2. Lifestyle changes (e.g., coping strategies)
3. Management of reversible causes (e.g., incident pain precipitants)
4. Modification of the pathological processes (e.g., antineoplastic therapies)
5. Symptomatic management of breakthrough pain (e.g., pharmacologic and nonpharmacologic)
6. Reassessment (e.g., evaluation of pain and management)

Characterizing BTCP

BTP Assessment Questions

- **PORSTU** (precipitating, palliating, previous treatment, quality, region/radiation, severity, temporal, (u) you [effect])
- Do you have episodes of severe pain or BTP?
- How many episodes of BTP do you have each week? Each day?
- How long is it from the time the pain first occurs to when the pain is at its worst?
- How long does each episode of BTP last (minutes, hours)?
- On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how much does an episode of BTP hurt when it occurs?
- Describe where the BTP occurs. What does it feel like?
- Is the BTP similar to or different from your baseline persistent pain?
BTP Assessment Questions

- Does your BTP occur with movement or other activity, spontaneously (not associated with any activity), or just before you are supposed to take your next dose of pain medicine?
- What impact does BTP have on your daily responsibilities at home/work? Are you able to do the things that you want/need to do?
- Are there any things that you avoid doing or that you are able to do only with severe pain?
- What do you do to relieve the pain?
- What types of treatments have you used? How long did you use them? Were they effective? Are they still effective?
- What drugs have you used to relieve the BTP? What were the doses? Were they effective? Are they still effective?

Lifestyle Changes

- Self-awareness of physical limitations
- Learn to pace/reduce activities to avoid precipitating pain; take breaks
- PT – warm up, stretching, posture, activity
- Use aides for ADLs (washing, dressing, cooking)
- Ice/heat packs, massage, exercise, repositioning, immobilization
- Cognitive behavioral techniques (hypnosis, relaxation, meditation) – need a specialist
- Patient education
- Avoid catastrophic thinking
Pharmacologic Management of BTCP

- End of dose deterioration strategies
  - Increase total daily dose of opioid
  - Shorten dosing interval
- Non-opioids may not resolve pain
- Preferred characteristics:
  - Opioid pharmacokinetics should match temporal characteristics of BTCP episode
    - Short acting
    - Rapid acting
  - Need to be able to titrate to higher or lower doses
  - Should not increase adverse effects

Pharmacokinetics of IR Opioids

<table>
<thead>
<tr>
<th>Solubility</th>
<th>IR Opioids</th>
<th>Onset of analgesia</th>
<th>Duration of effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrophilic</td>
<td>Morphine (oral)</td>
<td>30-40 minutes</td>
<td>4 hours</td>
</tr>
<tr>
<td></td>
<td>Oxycodone (oral)</td>
<td>30 minutes</td>
<td>4 hours</td>
</tr>
<tr>
<td></td>
<td>Oxymorphone (oral)</td>
<td>30 minutes</td>
<td>4-6 hours</td>
</tr>
<tr>
<td></td>
<td>Hydromorphone (oral)</td>
<td>30 minutes</td>
<td>4 hours</td>
</tr>
<tr>
<td>Lipophilic</td>
<td>Methadone (oral)</td>
<td>10-15 minutes</td>
<td>4-8 hours</td>
</tr>
<tr>
<td></td>
<td>Fentanyl (transmucosal)</td>
<td>5-10 minutes</td>
<td>1-2 hours</td>
</tr>
</tbody>
</table>

Rhiner MI et al. J Support Oncol 2010;8:232-238

Routes of Administration

- Oral and oral transmucosal
- Parenteral
- Rectal
- Sublingual and intranasal

Slow Onset, or Volitional Incident Pain

- EACH dose of rescue opioid (e.g., oxycodone, oxymorphone, morphine, hydromorphone) should be 10-15% of the TOTAL daily dose of oral long-acting opioid.
  - MS Contin 30 mg q12h
  - TDD = 60 mg
  - 10% - 6 mg; 15% - 9 mg
  - MSIR 5 or 10 mg q2h prn breakthrough pain
- Can offer every 2 or 4 hours (or hourly?)
- Rate pain before and after rescue opioid

Rhiner MI et al. J Support Oncol 2010;8:232-238
Case 1

- PJ is a 68 year old man with prostate cancer, receiving OxyContin 30 mg po q12h for persistent pain.
- He complains that when he has to go see his physician (which involved a ride in the car, transferring to wheelchair, etc.) his pain escalates significantly.
- What would be an appropriate dose of oxycodone oral solution for this patient and when should he take the dose?

Case 1

- His TDD oxycodone is 60 mg (30 mg po q12h)
- 10% = 6 mg; 15% = 9 mg
- Recommend 5 or 10 mg
- Onset is 30-40 minutes, peaks in about an hour, lasts for about 4 hours
- Recommendation: Take 5 (or 10 mg) 45-60 minutes before leaving home. Take an extra dose with you in case begins to return.

Case 2

- Mrs. Hendricks is a 54 year old woman with end-stage esophageal cancer.
- She is receiving TDF 75 mcg, every 72 hours for persistent pain.
- You would like to use morphine oral solution (20 mg/ml) for breakthrough pain. What does do you recommend?
- TDF 75 mcg ~ 150 mg TDD oral morphine
  - 10% = 15 mg
  - 15% = 22.5 mg
- Morphine oral solution, 20 mg every 2 hours as needed for breakthrough pain
- Keep a pain diary, rate pain before and after rescue opioid

Your Turn! Case 3

- A 48 y/o woman with metastatic breast cancer, receiving MS Contin 90 mg po q12h. She has a nasty chest wall wound for which the hospice nurses provides wound care, which causes significant pain. Which of the following would be an appropriate intervention?
  - A. Administer 10 mg oral morphine when the RN arrives
  - B. Tell patient to take 10 mg oral morphine 45 minutes before RN arrives
  - C. Administer 20 mg oral morphine when the RN arrives
  - D. Tell patient to take 20 mg oral morphine 45 minutes before RN arrives
When do you increase the long-acting opioid?

- If the patient is using multiple doses per day of their rescue opioid, when should we increase the long-acting?
  - Is rescue opioid being used for slow onset idiopathic pain, or volitional incident pain?
  - Only consider doses used for slow onset idiopathic pain in calculations
  - When 3-4 doses of rescue are used daily, consider increasing long-acting opioid
- As you increase the long-acting opioid, increase the rescue opioid as well

Case 4

- WC is a 68 year old man with colon cancer. His pain is being treated with MS Contin 60 mg po q12h and morphine oral solution 15 mg po q2h prn additional pain.
- Over the past week he has been complaining of increased pain. Nothing in particular brings the pain on, and it evolves over about 30 minutes. He tries to “hang on” but he feels pretty badly about 30-40 minute after the pain starts.
- He has been averaging about 4 doses a day of the oral morphine solution with good effect. What do you recommend?

Case 4

- Patient on MS Contin 60 mg po q12h = 120 mg po qd
  - Four doses per day of morphine solution x 15 mg a dose = 60 mg qd
  - TDD = 120 + 60 = 180 mg
- Increase MS Contin to 90 mg po q12h
- Increase morphine oral solution to 20 mg po q2h
  - 10% = 18 mg; 15% = 27 mg
  - Have patient keep pain diary

What about methadone?

- Rapid onset (10-15 minutes), good BAB
- Multiple mechanisms of action
- Good clinical results (with SL administration)
  - Reduces pain rating by 1.7 points after 10 min
  - Reduces pain by 3.2 points after 15 min
- Methadone has a long duration of effect (6-12 hours) and a very long elimination half-life
- With repeated dosing you risk accumulation

Hagen NA et al. Palliative Med 2010;24(76):696-706
Rapid Onset / Idiopathic / Nonvolitional Incident Pain

Rhiner MI et al. J Support Oncol 2010;8:232-238

Rapid Onset Opioids
Transmucosal Fentanyl

- Actiq/Generic - is a solid lozenge of fentanyl on a plastic stick
- Fentora – a fentanyl tablet that uses OraVescent drug delivery technology
- Onsolis – a buccal soluble film of fentanyl
- Abstral – a rapidly disintegrating sublingual tablet formulation of fentanyl citrate

Rapid Onset Opioids Transmucosal Fentanyl

- Only indicated for the management of breakthrough pain in cancer patients ≥ 18 years old who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain.
- For a week or longer, patient taking:
  - Oral morphine 60 mg/day
  - Transdermal fentanyl 25 mcg/hour
  - Oral oxycodone 30 mg/day
  - Oral oxymorphone 25 mg /day
  - Oral hydromorphone 8 mg/day

Tolerance – a phenomenon in which exposure to a drug results in the diminution of an effect or the need for a higher dose to maintain an effect.

OTFC Lozenge (Actiq and generic)

- Opioid tolerant patients: Initial dose is 200 mcg
- If BTP not relieved in 15 minutes after completing previous dose (30 minutes after the start of the previous dose), an additional 200 mcg may be used.
- Patients must wait at least 4 hours before treating another episode of BTP with Actiq.
- Do not use more than 2 units for each BTCP episode; no more than 4 qd once dose determined.
- Strengths: 200, 400, 600, 800, 1200, 1600 mcg lozenges
Case 5

- AB is a 68 year old woman with lung cancer. She is receiving a long-acting morphine tablet 60 mg every 12 hours. Her physician prescribed oral morphine solution, 15 mg every 2 hours for breakthrough pain.
- Unfortunately, she tells you her breakthrough pain episodes evolve over a couple of minutes, peak in about 5 minutes, and last about 15 minutes.
- When she takes her oral morphine solution, the breakthrough pain has mostly resolved by the time the morphine kicks in, and it just makes her sleepy and a little nauseated. You decide to recommend an oral transdermal fentanyl citrate (OTFC) product. What dose do you recommend?

Case 5

- Morphine LA 60 mg po q12h
- Morphine oral solution 15 mg po q2h
- Which of the following do you recommend? Actiq (oral transmucosal fentanyl citrate, OTFC) is available as 200, 400, 600, 800, 1200, 1600 mcg lozenges
  - A. OTFC 200 mcg, may repeat in 30 minutes
  - B. OTFC 200 mcg, may administer 400 mcg in 30 minutes
  - C. OTFC 400 mcg, may repeat in 30 minutes
  - D. OTFC 400 mcg, may administer 600 mg in 30 minutes

Effervescent Tablet (Fentora)

- Opioid tolerant patients: Initial dose is 100 mcg
- If BTP not relieved in 15 minutes after completing previous dose (30 minutes after the start of the previous dose), an additional 100 mcg may be used. Do not use more than 2 units for each BTP episode.
- Patients must wait at least 4 hours before treating another episode of BTP with Fentora.
- Strengths: 100, 200, 300, 400, 600, 800 mcg

Conversion from Actiq to Fentora

<table>
<thead>
<tr>
<th>Current Actiq Dose (mcg)</th>
<th>Initial Fentora Dose (mcg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>100 mcg tablet</td>
</tr>
<tr>
<td>400</td>
<td>100 mcg tablet</td>
</tr>
<tr>
<td>600</td>
<td>200 mcg tablet</td>
</tr>
<tr>
<td>800</td>
<td>200 mcg tablet</td>
</tr>
<tr>
<td>1200</td>
<td>2 x 200 mcg tablets</td>
</tr>
<tr>
<td>1600</td>
<td>2 x 200 mcg tablets</td>
</tr>
</tbody>
</table>
Case 6

- AB, our 68 year old woman with lung cancer in Case 5 has experienced disease progression and she is now prescribed Actiq 600 mcg as needed for breakthrough pain.
- Unfortunately, she has grown too weak to retain the Actiq lozenge in her mouth, so her prescriber writes a prescription for Fentora 600 mcg as needed. Do you agree with this plan?

Case 6

- AB, our 68 year old woman with lung cancer on Actiq 600 mcg → Fentora 600 mcg (fentanyl buccal tablet) as needed for breakthrough pain. Your action?
  - A. Good plan, fill the prescription
  - B. Bad plan, start with 200 mcg Fentora tablet, may repeat in 30 minutes
  - C. Bad plan, start with 200 mcg Fentora tablet, may increase to 400 mcg in 30 minutes
  - D. Bad plan, start with 400 mcg Fentora tablet, may repeat in 30 minutes

Fentanyl Buccal Soluble Film (Onsolis)

- Opioid tolerant patients: Initial dose is 200 mcg
- Single doses should be separated by at least 2 hours. Onsolis should only be used once per BTP episode.
- If one 200 mcg Onsolis film does not relieve pain, use multiples of the 200 mcg film in subsequent BTP episodes.
- Strengths: 200, 400, 600, 800 and 1200 mcg

Fentanyl SL tablet (Abstral)

- Opioid tolerant patients:
  - Initial dose is 100 mcg
- If adequate analgesia is not obtained after 30 minutes a second Abstral 100 mcg dose may be taken.
- No more than two doses of Abstral may be used to treat an episode of BTP.
- Patients must wait at least 2 hours before treating another episode of BTP with Abstral.
- Strengths: 100, 200, 300, 400, 600 and 800 mcg
<table>
<thead>
<tr>
<th>Product</th>
<th>Time to Tmax (median)</th>
<th>Bioavailability (TM/Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actiq</td>
<td>20-40 min</td>
<td>25/50%</td>
</tr>
<tr>
<td>Fentora</td>
<td>35-45 min</td>
<td>50/65%</td>
</tr>
<tr>
<td>Onsolis</td>
<td>60-120 min</td>
<td>51/71%</td>
</tr>
<tr>
<td>Abstral</td>
<td>30-60 min</td>
<td>54%*</td>
</tr>
</tbody>
</table>

* Prescribing information does not specify TM vs. total (TM – transmucosal)

Looking to the future

- Sublingual opioids
  - Sufentanil, Ketamine
- Intranasal opioids
  - Bypasses hepatic first pass clearance
  - Morphine, hydromorphone, methadone, etc
  - Fentanyl, sufentanil, alfentanil, ketamine
- Parenteral opioids
- Nebulized opioids
- Rescue opioid rotation need to be explored


Limiting Abuse, Misuse, Diversion

- Pharmacist is the last line of defense protecting patients, public, society
- Screen patients for inappropriate medication-related behavior (doctor-shopping, etc.)
- Patients should be opioid tolerant
- TMF contraindicated in acute post-operative pain including headache/migraine

Six Steps to Zero – Patient Counseling

- Never take a prescription painkiller unless it is prescribed to you
- Do not take pain medicine with alcohol
- Do not take more doses then prescribed
- Use of other sedatives or anti-anxiety medications can be dangerous
- Avoid using prescription painkillers to facilitate sleep
- Lock up prescription painkillers

http://www.zerodeaths.org/
Limiting Abuse, Misuse, Diversion

- Always start with lowest dose
  - There are suggested starting doses when switching from Actiq to Fentora
  - Otherwise there is no established conversion or recommended doses for switching from one TMF product to another
- Participate in REMS program
- Assure that patient is already taking an around-the-clock opioid regimen

Limiting Abuse, Misuse, Diversion

- If the around-the-clock opioid regimen is discontinued, the TMF product must be discontinued as well
- Patients should NEVER share their TMF with someone else
- Query patient/caregiver understanding of TMF use, disposal
- Dispense an appropriate initial quantity in appropriate strength

Limiting Abuse, Misuse, Diversion

- Assist with titrating TMF
- Work with prescriber to assure patient is receiving no more than 4 TMF units per day
- Discuss how to open TMF unit, how to use it, and how to discard unused units with patient/caregiver
- Discuss appropriate dosing interval during titration with patient/caregiver

Limiting Abuse, Misuse, Diversion

- Monitor patient response to TMF
- Follow the “4 A’s”
  - Analgesia
  - Activities of daily living
  - Adverse effects
  - Aberrant drug related behavior
What is a REMS?

- A Risk Evaluation and Mitigation Strategy (REMS) is a program established under the Food and Drug Administration Amendments Act (FDAAA) of 2007. FDAAA grants FDA the authority to require a drug manufacturer to develop and implement a REMS if FDA determines that a REMS is necessary to ensure that the benefits of a drug outweigh the risks, while it is marketed.

- Links to approved REMS can be found on the FDA website at http://www.fda.gov/Drugs/

Onsolis™ (Fentanyl Buccal Soluble Film)

Focus Program: Steps

- Patient, prescriber, distributor and pharmacy must enroll
- Prescriber sends prescription via courier
- FOCUS pharmacy confirms patient/prescriber eligibility, patient counseling, preparation and arranges for delivery
- Upon receipt of prescription, pharmacy dispenses and delivers medication

Abstral Proposed REMS Strategy

- Goals of the REMS Program are to mitigate the risk of misuse, abuse, addiction, overdose and serious complications due to medication errors by:
  - Prescribing and dispensing Abstral only to appropriate patients, which includes use only in opioid-tolerant patients
  - Preventing inappropriate conversion between fentanyl products
  - Preventing accidental exposure to children and others for whom it was not prescribed
  - Educating prescribers, pharmacists, and patients on the potential for misuse, abuse, addiction and overdose.


Abstral Proposed REMS Strategy

- Medication Guide
- Healthcare providers who prescribe Abstral for outpatient use are specially certified
  - Must review prescriber educational materials and successfully complete the knowledge assessment (Prescriber Education Program, Prescriber Knowledge Assessment)
  - Complete and sign the Prescriber Enrollment Form, acknowledging a series of statements regarding the appropriate use of Abstral
  - Complete and sign a Patient-Prescriber Agreement with each new patient, and renew every two years (acknowledges appropriateness of each patient); patient acknowledge s/he has been educated and how to use medication. Patient, provider and REMS program are copied.

Abstral Proposed REMS Strategy

- Abstral may only be dispensed by pharmacies that are specially certified
  - There is a different set of enrollment requirements for outpatient pharmacies (e.g., retail, mail order, institutional outpatient pharmacies) and inpatient pharmacies (e.g., hospitals, hospices, and LTC facilities)
  - Outpatient pharmacists must complete the education program and successfully complete a knowledge assessment (Pharmacy Education Program, Pharmacy Knowledge Assessment).
  - Authorizing pharmacist signs the Pharmacy Enrollment Form. Their signature acknowledges risks of therapy and appropriate product use.
  - Similar procedure for inpatient pharmacies. Pharmacies re-enroll every two years.


Abstral Proposed REMS Strategy

- Abstral may only be distributed by wholesalers/distributors who are enrolled in the REMS program
  - Wholesalers/distributors must complete and sign the Distributor Enrollment Form.
- ProStrakan will submit REMS Assessments to the FDA every six (6) months for the first year following the approval of the ABSTRAL REMS, and annually thereafter. To facilitate inclusion of as much information as possible while allowing reasonable time to prepare the submission, the reporting interval covered by each assessment should conclude no earlier than 60 days before the submission date of the assessment. ProStrakan will submit each assessment so that it will be received by the FDA on or before the due date.


Your turn again!

- WY is a 74 year old man with esophageal cancer. He is on transdermal fentanyl 150 mcg every three days for persistent pain (he has difficulty swallowing). His prescriber asks you what is the dose of OTFC to use for this patient’s breakthrough pain.
- Note: you know that transdermal fentanyl 150 mcg is about equivalent to 300 mg oral morphine per day.


Your turn again!

- WY is a 74 year old man with esophageal cancer. He is on transdermal fentanyl 150 mcg every three days. Starting Actiq dose?
  - A. 200 mcg
  - B. 400 mcg
  - C. 600 mcg
  - D. 800 mcg
Another case for you to ponder...

- HG is a 48 year old man with rectal cancer. He is receiving OxyContin 40 mg po q12h for persistent pain. His oxycodone oral solution is too slow in relieving his pain and his prescriber starts the patient on Abstral 100 mcg sublingually, every 2 hours as needed.
- The patient calls you to complain that one Abstral 100 mcg tablet is not sufficient. How should this patient’s dose be titrated?

Another case for you to ponder...

- OxyContin 40 mg po q12h
- Abstral 100 mcg sublingually, every 2 hours as needed. Which of the following statements are correct?
  - A. He may repeat the 100 mcg dose 30 minutes after the first tablet
  - B. If 200 mcg doesn’t relieve his pain, in two hours he can take three 100 mcg Abstral tablets, and may repeat in 30 minutes
  - C. If 300 mcg doesn’t relieve his pain, in two hours he can take four 100 mcg Abstral tablets, and may repeat in 30 minutes

One for the road...

- Which of the following statements are correct regarding transmucosal fentanyl products?
  - A. TMF products are only indicated for the management of BTCP, in OPIOID-TOLERANT patients
  - B. TMF products may NOT be used for acute or postoperative pain, including headache/migraine
  - C. Alright, already – they’re ALL correct!

Conclusion

- Breakthrough cancer pain is a serious problem for cancer patients and should be carefully assessed.
- Treatment strategies should be selected based on the characteristics of the patient’s pain and may include:
  - Altering the patient’s analgesics for persistent pain
  - Pre-medicating before predictable BTCP episodes (e.g., oral morphine or oxycodone)
  - Recommending rapid-acting TMF products for more rapid onset, short-lived BTCP episodes
- At all times, HCP must safeguard individual patients, the public and society as a whole drug misuse, abuse and diversion.