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PHS Fentanyl Patch Policy

Overview

PHS HealthCare offers the full continuum of care for people with opioid use disorder, including oral options such as methadone, buprenorphine/naloxone, and Slow Release Oral Morphine (SROM), as well as injectable options such as hydromorphone and tablet hydromorphone.

The fentanyl patch is another option in this continuum of care for people who have not been able to stabilize on oral treatment.

Just like our iOAT program, people will have the option to have co-prescribed OAT along with their fentanyl patch. Ideally people will only be on both temporarily and transition to the patch alone.

Indications

This program is for people with opioid use disorder, as well as chronic pain, who have been unable to stabilize on oral treatment alone. It is for both people who are IV drug users as well as opioid smokers and nasal users.

Patients who have not stabilized on iOAT may be considered for fentanyl patch in addition to their injectable hydromorphone treatment.

Precautions:

- An acute clinical condition that would increase the risk of an adverse event with the use of the fentanyl patch.
- Caution should be exercised for fentanyl patch patients who have existing injection-related infections (e.g., septicemia, endocarditis, pneumonia, infective osteomyelitis), and in individuals with coagulation disorders (e.g., patients prescribed anticoagulants, severe hepatic disease, deep vein thrombosis) or a history of recent head injury.
- If any of these precautions newly arise during care, notify the physician immediately.
- Alcohol and/or benzodiazepine use. There can be exceptions based on clinical judgment if the benzodiazepines are from contamination of illicit fentanyl. However, the goal of the program is to eliminate illicit fentanyl, so illicit benzodiazepines would also be eliminated. If the person is not sedated, it is reasonable to start the program, even with benzodiazepine positive urine tests.
- Pregnancy

Contraindications:

- New or evolving physical health conditions that exclude the use of high dose opioid treatment or could be worsened by high-dose opioid treatment (e.g., severe respiratory disease requiring long-term oxygen, renal failure, hepatic failure).

SPECIAL CAUTION

There is a severe interaction with Ritonivir and Stribild, Genvoya, and Prezcobix. These ARVs slow the metabolism of fentanyl quite significantly.

If someone is stable on an ARV regimen, and you start fentanyl, go slowly and be cautious with monitoring for sedation.

If someone is on and off ARVs, they wouldn't be appropriate for the fentanyl patch program, due to the changes in fentanyl metabolism.

Someone who is on the fentanyl patch is at risk of overdose if they are started on ARVs (such as if they require post exposure prophylaxis). Before starting ARVs, call and discuss with the HIV pharmacist. They may require a fentanyl adjustment, or a specific ARV regimen to account for the fentanyl patch dose.

Evidence

There is currently no evidence to support using fentanyl patches for treating opioid use disorder in the context of chronic pain. However, there is extensive evidence and provincial guidelines that support the use of long acting opioids such as methadone, buprenorphine, and slow release oral morphine to treat opioid use disorder.

As the provincial overdose emergency continues, PHS has a goal of evaluating new strategies to engage individuals in care. For this program, we are extrapolating this evidence to apply to a different formulation and category of long acting opioid, which has not been studied for this purpose. This is an off-label use of this medication.

While the scientific literature in this area is minimal, in Vancouver, many physicians in our community of practice are already successfully using this intervention to treat people with opioid use disorder and chronic pain.

Evaluation

Our program will be evaluated by the British Columbia Centre on Substance Use.

Enrolling patients on the program

A PHS physician will enroll patients in this program. The physician will assess the person for opioid use disorder and other substance use, as well as previous treatments and outcomes. The physician will also obtain a pain history. The physician will use the same assessment and inclusion criteria as per the iOAT patient guidelines. Patients who smoke or snort opioids are also eligible for this program.

Each person will have two physicians review and sign off on their chart before starting the fentanyl patch program. This needs to be documented in the ongoing concerns section of the chart: “Has 2 physician approval for fentanyl patch program”.

Each patient will have a urine drug test that is confirmed positive for an opioid by Life Labs before starting the program. Each patient will have baseline liver and renal function tests.

If another physician in the community follows the patient, that physician will be consulted before starting the fentanyl patch program.

Physician Checklist before starting the patch

1) Special Authority approval received (see Patch Ordering below for exceptions)
2) Baseline liver and renal blood work done within the last 3 months and reviewed. This is not required for a start, but is a consideration depending on comorbid conditions.
3) Approval from two physicians completed
4) Flovent ordered to mist on skin prior to patch application
5) Diagnostic code E827 (Fentanyl Patch Program) added to Disease Registry

6) Sarah Foster messaged for tracking

Medication Coverage

Medication coverage will be arranged through a Special Authority application by the physician.

Special Authority is approved for fentanyl patches for chronic pain. The Special Authority process must be completed before starting a person on the medication, including a confirmation fax of approval from Pharmacare.

Confirmation of fax of approval from Pharmacare will be received by the MOA, faxed directly to Community Apothecary and uploaded to the patient's chart.

The Special Authority form is filled out by the physician who does the first approval.

Example: Pain management for severe chronic pain unresponsive or intolerant to conventional, titrated, opioids such as methadone, morphine and hydromorphone.

Titration schedule

All dose changes are done by a physician, and require a chart note for documentation

The two options to initiate the fentanyl patch are described below. Note that fentanyl patch dose and oral OAT dose cannot be titrated at the same time. Patients can first titrate on SROM and convert to the fentanyl patch, or they can titrate the fentanyl patch alone.

SROM to Fentanyl protocol

Patients can undergo a SROM titration, as per the PHS regular SROM titration schedule. When they have reached a dose where they are comfortable, the physician can convert the dose over to the fentanyl patch.

For Fentanyl patches, typically there is not a 25% dose reduction when converting to transdermal fentanyl patches, as incomplete cross tolerance is already taken into account in the product monograph conversion charts when converting from oral morphine equivalent to fentanyl patch. Fentanyl patches are the only opioid where this is already accounted for; all others require dose reduction when rotating to a new opioid. While some doctors feel more comfortable dose reducing regardless, a 25% dose reduction from stable SROM dose may result in significant under-dosing upon rotation to the patch, unless the reason for 25% dose reduction is not related to the issue of cross-tolerance.

There is an option to still decrease the dose on conversion, but less than the traditional 25% dose reduction when converting between opioids. This would be for patients where the clinician is very concerned about tolerance.

During this transition, most patients will require some prn short-acting medications. It is reasonable to bridge them with some hydromorphone tablets daily dispensed to alleviate any discomfort they have with the transition. A reasonable dose is 2 - 14 tablets of 8mg hydromorphone per day at 1-2 tabs q1 hour prn. This can be adjusted, depending on the fentanyl patch dose, and known opioid tolerance.

The fentanyl patch (or patches) is ideally administered **12 hours** after the last SROM oral dose, as it takes 12 hours for the patch to start to take effect, and 24 hours for the patch to reach the expected serum concentration. SROM remains at steady state for 24 hours, then serum concentration drops quickly. This schedule provides a smooth cross titration over 24 hours. 12 hours post SROM dose is challenging due to business hours of clinical services. Less or more time is appropriate for this change, as the clinician is able to accommodate with clinic hours.

Fentanyl Patch Titration

There are two titration options, depending on the person's known tolerance.

1.
If someone has an unknown tolerance, you can choose a more conservative titration schedule.
Initial dose - 25mcg-50mcg
Increase weekly by 25 - 50mcg

2.
If someone has a known high tolerance, such as if they have ongoing documentation of fentanyl positive in their urine drug tests, or have been on the patch before, the physician can select a fast titration schedule.

In the rapid titration schedule, the fentanyl patch dose can be adjusted after two consecutive doses, but the prescription must be submitted to the pharmacy on the day prior. Rapid titrations are currently only available at the Molson and Columbia Street Community Clinic, please refer to site specific protocols.

For example:

Monday - Fentanyl Patch 100mcg
Wednesday - Fentanyl Patch 100mcg
Friday - Fentanyl Patch 150mcg
Monday - Fentanyl Patch 150mcg
Wednesday - Fentanyl Patch 200mcg
Friday - Fentanyl Patch 200mcg

OAT maintenance with addition of Fentanyl

Some people on OAT will want to continue on their current OAT, but find that they are still using illicit drugs, and having ongoing pain, and would like to have a fentanyl patch in addition to their OAT.

For these patients, they have the option to initiate a fentanyl patch in addition to their regular OAT dose. Once they have started a fentanyl patch titration, do not further adjust their OAT dose until they have been on a stable fentanyl patch dose for 1 week.

For those on a stable dose of OAT, their fentanyl dose can be adjusted every two doses.

	Unknown tolerance (mcg/hr)	High tolerance (mcg/hr)	
Monday	25	100	
Wednesday	25	100	
Friday	50	150	
Monday	50	150	
Wednesday	100	200	
Friday	100	200	
Monday	125	250	

The patient can continue to titrate up by 25- 50mcg after two patch changes at each dose. When titrating, consider if the person is still feeling withdrawal or cravings.

If the patient is re-titrating, or has a known high tolerance, severe pain, or large amount of illicit drug use, they can increase their weekly dose by 10-20% or 50mcg (whichever is higher) when titrating.

There is no maximum dose in this program. Each dose increase is done by a physician and includes patient evaluation, history, discussion of goals, physical exam, and mental status exam. Above 1000mcg is a watchful dose where the physician can be more cautious and consider asking a second physician to review the chart.

Once the patient is on their maintenance dose, they will present to the nurse three times weekly for patch changes, ongoing (Monday/Wednesday/Friday).

Most patients will have a goal of being on the patch alone, without OAT. In some exceptional, well documented circumstances, the patient may remain on both the patch and oral OAT.

Maintenance on the Program

Each patient has a check in with the nurse every Monday, Wednesday, Friday for their patch changes. The nurse uses the Fentanyl Patch Change OSCAR template to document the visit.

Each patient has a monthly case conference review by the clinical team. The team discusses engagement, progress to recovery, and any clinical concerns.

Vitals, Urine Drug Testing, and weight will be monitored monthly.

Each patient should be seen by a physician at least monthly.

Patch Ordering

Before writing a prescription, the physician will confirm that the Special Authority has been approved for the patient. This can be done by checking the chart to confirm that we have received a confirmation fax from Special Authority indicating that fentanyl patches are "approved," or by calling the pharmacy to check on the status of approval.

All prescriptions that are administered within PHS will be filled by our pharmacy partner, Community Apothecary.

If Special Authority has been applied for, but the delay in processing may create a barrier for the patient, the patch may be started prior to Special Authority approval. This should be communicated with Community Apothecary directly for each patient, and the medication costs will be billed to the SAFER program until the Special Authority has been approved.

Patches are always dispensed to the clinic or to a nurse, they are never dispensed directly to a patient.

When ordering a fentanyl patch the physician will indicate on the prescription:

Medication: Fentanyl Patch
Quantity: refers to the number of patches you are prescribing,

Ex. "Fentanyl 200mcg/hr patch. 6 patches. Patch change Mon/Wed/Fri. Dispense 3 patches every 7 days"

Then the pharmacy can interpret this and dispense 6x100mcg/hr patches each week x 2 weeks

Prescriptions

Quantity= total number of patches
Directions for use: Fentanyl patch _____ mcg per hour
Patch change Monday/Wednesday/Friday by nurse
Daily Dispense or Weekly dispense depending on your site protocol

Deliver to [site]
Date range (7 days for a titrating patient, 28 or 56 days for a stable patient)

We have **no same day starts** for the fentanyl patch program, as the pharmacy needs sufficient time to process and deliver the medication.

The ward stock supply of fentanyl patches is for restarts, dose adjustments after missed doses, and dose increases (only applicable to certain sites, see site protocol). It cannot be used for new starts.

Dose increases and decreases always require a documented assessment, physician's order, and must be approved by the pharmacy prior to application.

Fentanyl patches will be stored in the safe on-site.

The pharmacy will deliver the patches either weekly or 3 times per week (Monday, Wednesday, and Friday.

Duration of prescriptions

Titration prescriptions will be one to four weeks in duration (3 – 12 doses) daily dispensed.

Maintenance prescriptions will be 28 or 56 days in duration (12 or 24 doses) daily dispensed.

Missed Dose Protocol

This missed dose protocol assumes that the patch is still on the skin, and intact. If the patch is not in situ and the patient cannot present the patch, refer to the Diversion section of this policy.
Count the days beginning with the first day after a patch change as Day 1. Each patch contains enough medication to last for 3 days (72 hours), but due to the accumulation of fentanyl, and based on clinical experience, this protocol does not require a dose decrease until 6 days after the last patch change.

So, if someone gets a new patch on Monday, and doesn't come back into the clinic, they require a dose adjustment starting on Sunday. If they had come Tuesday to Saturday, they would receive the same dose.

5 days or less since the last patch change - no change to dose.

Example: Someone has a new patch on Friday. They miss their patch change on Monday. They come to the clinic Wednesday - this is 5 days after their most recent patch change. There is no need to change the dose.

6-7 days since the last patch change - decrease dose by 30%.
8-9 days since the last patch change - decrease dose by 50 %

If it has been 10-14 days since their last patch change, they re-start their titration from the beginning. After 15 days, they must see a physician to discuss a plan to restart.

Example: If a patient is due for a patch change on Wednesday, and misses this day, and next comes to the clinic on the following Thursday (10 days after their most recent patch change), they must start titration from the beginning. The nurse will administer the original starting dose of 50mcg/hr.

Patients can restart on the starting dose for up to and including 14 days after the last patch change. If they have not presented to the clinic for more than 14 days, they need to see a physician to restart. They are not able to restart through the on-call physician, they must see the physician in person at the next scheduled clinic.

Day of the week	Patch change	Day Counter	Dose
Monday	Gets a new patch		
Tuesday		1	
Wednesday	Misses patch change	2	
Thursday		3	No change
Friday		4	No change
Saturday		5	No change
Sunday		6	30% reduction
Monday		7	30% reduction
Tuesday		8	50% reduction
Wednesday		9	50% reduction
Thursday		10	Restart titration
Friday		11	Restart titration
Saturday		12	Restart titration
Sunday		13	Restart titration
Monday		14	Restart titration
Tuesday		15	Not eligible for restart- must see physician

For dose decreases, round up to the nearest 25mcg/hr. So, if someone is on 175mcg/hr, and needs a 50% dose reduction, they would receive 100mcg/hr.

All patients will restart at 50mcg/hr, although physicians may decide on a case by case basis to restart at 100mcg.

When we restart after missed doses, the patient should be put back on the Monday/Wednesday/Friday patch change schedule by the next dose.

Missed patch change after dose increase

Patients may increase as long as the new dose is applied within 3 days of the previous patch change. If it has been 4-5 days since the last patch change, they go back to the previous stable dose. If it has been 6-7 days since the last patch was applied, their dose is reduced by 30%. If it has been 8-9 days since the last patch was applied, they reduce to 50% of the previous stable dose.

Ie. Yoseph gets his patch changed Monday and is scheduled for a patch increase on Wednesday. He presents to the clinic on Thursday. Since it is still within 3 days of his last patch on Monday, he is still eligible to increase.

Ie. Mac gets their patch changed on Friday and is scheduled for a dose increase Monday. They present to the clinic on Tuesday. They are not eligible to increase since Tuesday is 4 days since their last patch change. Mac will stay on the same dose as they received on Friday.

Day of the week	Patch change	Day Counter	Dose
Friday	New patch		
Saturday		1	
Sunday		2	
Monday	Misses patch change - this was a planned increase	3	
Tuesday	Presents to clinic	4	Same dose as Friday
Wednesday		5	Same dose as Friday
Thursday		6	30% reduction from Friday's dose
Friday		7	30% reduction from Friday's dose

Saturday		8	50% reduction from Friday's dose
Sunday		9	50% reduction from Friday's dose
Monday		10	Restart titration
Tuesday		11	Restart titration
Wednesday		12	Restart titration
Thursday		13	Restart titration
Friday		14	Restart titration

Dose decreases due to missed patch changes

Each location will follow their site-specific Fentanyl Patch Protocol.

Retitration

Patients who have been on a stable dose of the fentanyl patch for at least 4 weeks and have had a dose reduction, may be eligible for a more rapid retitration. This will be decided by the physician on a case by case basis.

The physician may decide to restart at 100mcg. The dose can be increased by 50mcg or 10-20% (whichever is greater) every patch change.

Urine Drug Testing

Patients will be required to provide monthly urine drug testing for this program, including a Fentanyl Confirmation test. Ongoing use of illicit fentanyl will not be able to be discerned by urine drug testing, unless the person is using illicit fentanyl analogues such as carfentanil or furanyl-fentanyl that are seen on fentanyl confirmation urine drug testing. The goal will be to have cessation or reduction of other opioid use outside the program.

If a patient declines to provide a urine drug test for 3 months, their next dose will be held until they can provide a urine.

Ongoing positive urine drug tests are not a reason to discharge someone from the program as the patient may have experienced other benefits such as decreased illicit drug use, housing stability, and engagement in primary care.

Clinical Considerations

Clinicians should consider the following when dosing patch strength of patch changes:

- Patient's body composition. Those with low body fat may require more frequent patch changes, although our program has baseline 48 hour changes, so this may never be required.
- Hepatic and renal function
- Drug-Drug interactions, including CYP inhibitors and inducers (commonly prescribed - ritonavir, fluoxetine, paroxetine, trimethoprim/sulfamethoxazole, ciprofloxacin, fluconazole, cimetidine)
- High heat can affect metabolism of drug from patch, such as having a fever or hot bath, or performing intense physical activity can increase absorption

*Discussion with the pharmacist is encouraged when considering these clinical factors

Fentanyl Patch and OAT co-prescribing

Most patients will have OAT co-prescribing with their patch. The goal is to have them on the patch alone, if that is clinically stable for them.

The fentanyl patch titration schedule is the slowest of all the OAT titrations. When someone is titrating up on their fentanyl patch, oral OAT cannot also be titrated up the same day. You can offer the patient to taper down on OAT the same day as a fentanyl patch increase.

Exercise caution when doing cross titrations between OAT and the fentanyl patch.

Diversion

Missing patches that cannot be accounted for will be considered an example of diversion.

A patch that has signs of tampering will be considered an example of diversion.

If a patient reports that their sweat has caused the patch to fall off, and they are able to present the intact patch, this is not considered diversion.

Diversion- 1st Attempt

Explore the reasons behind the diversion with the patient, in a supportive, and non-judgemental way.
Document the diversion attempt in their chart under Ongoing Concerns ie. "attempted diversion x1 14/04/2021"

Advise the patient that subsequent diversion attempts may result in a conversion to oral OAT or removal from the program.

Discuss with the team strategies to support the patient- do they require a higher dose, an increase to their OAT, or some other option.

Diversion- 2nd Attempt

Explore the reasons behind the diversion with the patient, in a supportive, and non-judgemental way.

Update the previous diversion attempt in their chart under Ongoing Concerns ie. “attempted diversion x2 16/04/2021”

Advise the patient that if there is another incidence of diversion, they will be converted to oral OAT for a period of 5 days, or potentially removed from the program.

Discuss with the team strategies to support the patient- do they require a higher dose, an increase to their OAT, or some other option.

Diversion- 3rd Attempt

Hold all subsequent doses (excluding non-narcotic medication and OAT)

Discuss with the team, and make a plan for the patient.

- Is it safe/reasonable for the patient to continue getting their medications on site, or will they need to be temporarily moved to an outside pharmacy?
- Are they able to return to the program, or should they see a physician to discuss other options?

Advise the patient whether theor medication will be changed to oral OAT for a period of 5 days, or if they are being discontinued from the program. If the patient’s medications need to be transferred elsewhere, ask the patient which pharmacy they would like to attend while they are on break, and let them know their medications will be sent there. In situations where the team has decided it is not appropriate for the patient to return, the patient should be directed to follow up with a physician to discuss alternative options.

Document the diversion in the Oscar chart note, including the pharmacy they would like to temporarily receive their medication from (if applicable) and contact the physician of the week for conversion to oral OAT.

Update the previous diversion attempt under Ongoing Concerns to “diversion x3 20/05/2021, converted to PO OAT until DATE or “diversion x 3 20/05/2021, not returning to Fentanyl Patch Program”

Subsequent Diversion Incidents

To be discussed as a team, moving the patient to a different medication option may be necessary.

Injectable Opioid Agonist Treatment

Patients on iOAT have the option of using the fentanyl patch as their long acting opioid to pair with their injections. The fentanyl patch would replace their other long acting medication, such as methadone or SROM.

In this circumstance, the patient has to be fully discontinued from their oral long acting medication before starting the fentanyl patch. They cannot be on iOAT, oral OAT, and the fentanyl patch at the same time.

The titration schedule would be the same as if starting the fentanyl patch while on OAT alone, with a start at 50mcg, and an increase weekly or every second patch change, depending on clinical discretion.

Some patients may benefit from a fixed dose prn iOAT schedule while doing the patch titration.

Discontinuation of the Program

For patients who are on the fentanyl patch as well as OAT, and are being discontinued due to diversion, the patch can be discontinued, and the patients will continue on their OAT dose. They can undergo a regular OAT titration schedule. Titration up of OAT **should not** begin until at least 17 hours after the patch has been removed.

If the person is on fentanyl patch alone, and is being discharged from the program due to diversion, they will undergo a normal OAT titration from the beginning of the titration (i.e Methadone start at 40mg, or SROM start at 300mg). If the OAT start is due to diversion, you can start the OAT immediately (considering other potential contraindications).

If a patient is self-discharging from the program, not due to diversion, their fentanyl patch can be stopped and converted to oral SROM. There is no option to directly convert to oral methadone, due to variability in methadone metabolism.

Physicians should use the following resource to convert to oral SROM. There is no need to do a dose reduction for cross tolerance, as this is already calculated into the patch dosing. The first oral dose should not start until **more than 24 hours** have elapsed post patch removal.

http://nationalpaincentre.mcmaster.ca/opioidmanager/documents/opioid_manager_switching_opioids.pdf

See appendix for a copy of the conversion chart.

Fentanyl Patch Procedure

Medical Office Assistants

All special authority approvals will get faxed directly to Community Apothecary and uploaded to the patient chart.

Any medication received from the pharmacy will always be given to the nurse immediately.

Each time a patient switches pharmacies for their OAT, their new OAT pharmacy needs to be sent the fentanyl patch program notification letter. This communication will prevent the pharmacy from cutting the patient off their OAT when they see fentanyl patches filled on PharmaNet.

This information can be found in Oscar under templates “FTY Patch Pharm Note”.

Copy and paste text into the PHS letterhead from the patient's chart and fax to the pharmacy.

Nursing

Nursing checklist

Before applying the **first** patch, the nurse will complete the pre-program checklist (Oscar template FTY Patch Checklist):

- Urine drug test confirmed at Life Labs, showing opioid positive and benzodiazepine negative
- Urine pregnancy test negative (if applicable)
- Baseline vitals and weight
- Confirm and document that there are no children in the home. Discuss Pet safety.
- Confirm that two physicians have approved starting the patch program
- Confirm the patient has had baseline liver and renal blood work results within 3 months that have been reviewed by a physician. This is not a requirement, but a consideration with other comorbidities.
- Confirm with the Community Apothecary that the fentanyl patch is covered by Pharmacare
- Set a tickler for 11 months after approval date to reapply for Special Authority
- Confirm the patient has had overdose training and a take home naloxone kit.
- If the patient receives OAT at another pharmacy, ensure the fentanyl patch program notification card has been faxed to their pharmacy to avoid the patient being cut off their OAT.
- Confirm that E827 - Fentanyl Patch Program has been added to the Disease Registry by the physician

- Ensure Sarah Foster has been notified via Oscar message for tracking

Once a client presents to the nurse and has been identified as a fentanyl patch patient, proceed by:

· Completing a nursing assessment using the SAFER F Patch Change OSCAR template, documenting:

S/
How patient is tolerating the current dose?:
Drug and alcohol use since last visit : Specify drug, amount, and route of use-ie. $20 heroin IV daily, 5 beer/ week, 2 points of crystal meth smoked TID
Mood:
Sleep:

O/
General appearance:
LOC:
Pupil size:
and location of patches:
Any signs of tampering? ie. tegaderm not intact, patient removed patches prior to assessment, etc
Vitals (monthly): ensure these are entered in the measurement function when taken
Weight (monthly): ensure this is entered in the measurement function when taken
UDT (monthly): ie. due dd/mm/yy ; collected-next due dd/mm/yy ; overdue-declines

- If a client has not provided a UDS in 3 months, advise their next dose will be held until they can provide a urine.

A/
patches removed:
Flovent spray applied prior to patch application?:
# of patches applied and location:
Covered with tegaderm, signed and dated

P/
Next dose due:
Expected dose:
Any follow up required:

Discuss with the physician if there are any concerns.

<u>APPLICATION</u>

- Always check the chart and MAR to assess when the last patch was placed and how many were applied to ensure removal of all patches before the new application. There is ongoing fentanyl absorption from a patch for many days after it is due to be changed.
- A nurse, pharmacist, or physician will perform all fentanyl patch administration.
- After completion of the Patch Visit template, the nurse will obtain the fentanyl patch from the safe for application
- Patches should not be used if the seal is broken or damaged
- Patches should not be cut or changed in any way.
- Patches must only be applied to dry, intact, non-irritated skin on a flat surface such as the chest, back, flank, or upper arm.
- In persons with cognitive impairment, the patch should be put on the upper back to avoid chances that patch will be removed.
- Hair at the application site may be clipped but NOT SHAVED prior to application.
- Do not use soaps, oils, lotions or any other agent on the patch site that might irritate skin or alter its characteristics.

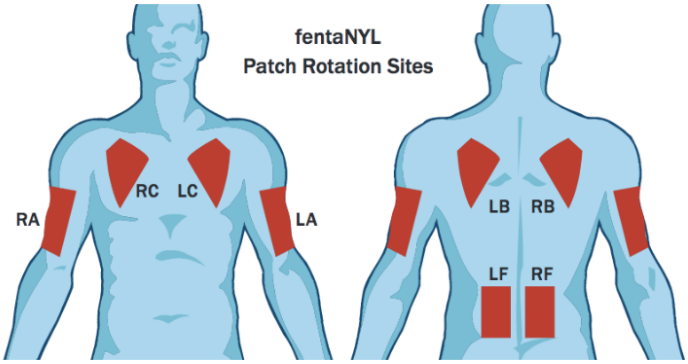
  *Note- for clients who experience skin irritation related to the Fentanyl Patch or covering dressing, you may mist Flovent on the skin prior to each patch application.
- **Wear gloves to avoid the transfer of medication. If you have been exposed to the FTY patch (ex: not wearing gloves and adheres to skin) - remove the patch immediately and irrigate the exposed area under cold water. Call Poison Control (604) 682-5050. DO NOT wash the exposed area with soap or any solvent, as this will increase absorption. Notify your nurse lead ASAP.**
- Apply the patch immediately upon removal from the sealed package.
- Remove the protective backing and apply by pressing firmly with the palm of the hand for 30 seconds, making sure the edges are sealed.
- Never write directly on a transdermal patch. Writing on the patch is generally not advised by manufacturers due to unknown risks, including risk of tear or puncture by pen/marker; interaction of ink and patch; or effect of ink on medication delivery.
- Secure the patch using only clear occlusive dressing such as Tegaderm hydrocolloid (never cover a patch with an opaque bandage or tape, with the risk the patch may not be seen to be removed)
- Use multiple, smaller pieces of tegaderm instead of a large sheet to avoid air bubbles
- If air bubbles are present, try to release the air bubble by pushing it to the side.
- If air bubbles remain, carefully use blunt tipped scissors to make a small incision to release the air. Never use an implement other than blunt tipped scissors to make an incision in the tegaderm..
- Cover any incisions made with more tegaderm to ensure the tegaderm remains waterproof and sealed.
- Sign and date the Tegaderm dressing and indicate the next patch change date.

Patches prescribed for one patient can never be used for a different patient.

REMOVAL

- Removal of the previous fentanyl patch or patches requires inspection for any damage or tampering
- If the patch is **not** intact, alert the physician before proceeding
- Patches should never be disposed of in the common garbage.
- Patches are to be folded in half and adhesive sides must stick together
- Patches must be disposed of in a tamper proof sharps container that is wall mounted with a lock or in a locked cupboard, witnessed by two nurses.
- Removal of the secured container from the site will be picked up by Biomed or Stericycle (depending on site) as fentanyl patches are considered hazardous waste

Patch Rotation Sites:



SITES	CODE
Left Upper Arm	LA
Right Upper Arm	RA
Left Chest	LC
Right Chest	RC
Left Upper Back	LB
Right Upper Back	RB
Left Flank	LF
Right Flank	RF

Image accessed at: https://www.remedysrxsp.ca/fentaNYL_Facts.pdf

Patches should not be reapplied to the same site within 7 days to avoid skin irritation when rotating.

The one exception is when a patch is changed in 24 hours or less. In these instances, the patch should be applied to the same site as the previous patch. This is to prevent additional fentanyl from being absorbed when a patch must be changed faster than the regular schedule.

Example: Latisha misses her patch change on Wednesday and receives a new patch on Thursday. The nurse places it on her left deltoid. On Friday, the old patch is removed and a new patch is placed on her left deltoid. When she returns on Monday, the new patch must be placed on a different site.

Documentation

- Nurses will document in OSCAR using the Fentanyl Patch Change template.
- All patch changes will be documented in the MAR.

- All patch disposals will be documented in the MAR with a second nurse witnessing and signing off.

- Patches must be accounted for in the Narcotic Count. Counts should be done twice daily (AM/PM) with two nurses where possible. This does not apply to daily dispensed patches.

- For projects where only one nurse is present, one nurse may sign, and the site will be subjected to additional narcotic audits from management.

Titrating patients

- If a patient is in the titration phase, complete the patch visit template, and determine if they would like to go up on their dose, or remain at their current dose.
- If the patient would like to go up on the dose, confirm they have been on the current dose for 2 scheduled patch changes, document your assessment, and consult the physician.
- The physician may want to see the patient for a visit for each titration, or they may feel comfortable going up on a dose based on the case conference with the nurse.
- The physician-nurse case conference must be documented with an OSCAR note.
- Fax the new prescription to Community Apothecary.
- Apply the new patch dose to the patient as per the patch application protocol (see below).

Maintenance patients

- If the patch is intact and the patient is at a therapeutic dose, apply the same dose patch , over a different area of skin, as per the patch application protocol.
- The patch change schedule is a new patch on Monday/Wednesday/Friday (3 per week).

    - Be cautious when a combination of patches is required to obtain the correct dose.
    - Confirm the correct combination of patches before application.
    - If the wrong patches are administered, they need to be removed, folded in half so the adhesive sides stick together, and disposed of in a tamper proof sharps container that is wall mounted with a lock or in a locked cupboard, documented and MD must be notified.

Missed Doses:

- Refer to the Missed Dose Protocol in the Fentanyl Patch Policy

Example 1: Counting missed days

Day of the week	Patch change	Day Counter	Dose

Monday	Gets a new patch		
Tuesday		1	
Wednesday	Misses patch change	2	
Thursday		3	No change
Friday		4	No change
Saturday		5	No change
Sunday		6	30% reduction
Monday		7	30% reduction
Tuesday		8	50% reduction
Wednesday		9	50% reduction
Thursday		10	Restart titration
Friday		11	Restart titration
Saturday		12	Restart titration

Example 2: Restarting after misses, put the person back on a Mon/Wed/Fri schedule

It is safe to get clients back on the Monday/Wednesday/Friday schedule as soon as possible, even if this means a patch is changed in only 24 hours. Please note that the patch site should **not** be rotated when doing short patch changes (within 24 hours)

Day of the week	Patch change	Day Counter	Dose
Monday	Gets a new patch		
Tuesday		1	
Wednesday	Misses patch change	2	
Thursday		3	No change
Friday		4	No change
Saturday		5	No change
Sunday		6	30% reduction

Monday		7	30% reduction
Tuesday	Comes in for a new patch	8	50% reduction
Wednesday	May get another new patch today. **Must be same site as Tues patch** Back on M/W/F schedule		
Thursday			
Friday	Next patch change due. **OR** If pt did not get a new patch Wed, they could get a new patch today without any change to their dose. Patch must be on a different site than Tuesday		
Saturday		1	

Example 3: Patients with missed doses who come in on Thursday will always have a patch day change on Friday.

Day of the Week	Patch change	Day Counter	Dose
Monday	Gets a new patch		
Tuesday		1	
Wednesday	Misses patch change	2	
Thursday	New Patch		No change
Friday	New Patch on same site as Thursday's patch - patient is back on MWF patch change schedule		No change
Saturday		1	

Sunday		2	
Monday	Patch Change		No change
Tuesday		1	
Wednesday	Patch Change		This is the first opportunity for a dose increase, as they have had two patch changes on schedule.
Thursday		1	
Friday	Patch Change		
Saturday		1	
Sunday		2	
Monday	Patch Change		

Clinical Cases

1. Sarge is on the fentanyl patch program at a dose of 300mcg (3 x 100 mcg patches). He has been doing well on this dose for a few months, but then he misses his Monday patch change. He presents to the clinic on Tuesday.

Sarge has missed 1 day of his fentanyl patch (Monday), so no dose adjustment is required. Apply the 300mcg dose of patches, and instruct him to return to the clinic on **Wednesday** for his next patch change. The patch on Wednesday will be placed on the same site as Tuesday.

Day of the week	Patch Change	Day Counter	Dose
Friday	Patch Change		300mcg
Saturday		1	
Sunday		2	
Monday	Misses dose	3	
Tuesday	New Patch		No change - 300mcg
Wednesday	New Patch (same site as Tuesday's patch)-		300mcg

	back on M/W/F schedule		
Thursday		1	
Friday	Patch Change		300mcg

2. Priya is titrating on her fentanyl patch. She is at a dose of 175mcg and still experiencing withdrawal. She has been coming for all of her doses. She comes in on a Friday, requesting an increase. You discuss this with the physician at the clinic who writes an increase for her next dose (Monday) and charts about a case conference. The physician decides to go up by 50mcg, as she has a lot of illicit fentanyl use. On Monday, you apply 225mcg of fentanyl patches.

Priya comes in on the following Wednesday and Friday, as per the schedule for patch changes. You see her each time for her patch change, and use the fentanyl patch template in OSCAR to document how she is doing. There are at least two patch changes between dose adjustments. On Friday, you check in with her again about if she would like a dose increase for Monday. She reports that she would like to continue to increase, so you discuss with the physician, document a case conference, and the physician writes a new prescription for an increase starting on Monday, for 275mcg. We have several cases of samedsame Of same day increase lately. In this case, Priaya can have a top up dose on Friday if Dr approves it? Pryia got Monday and wednesay doses then he cawn

Day of the week	Patch Change	Day Counter	Dose
Friday	175mcg		
Saturday		1	
Sunday		2	
Monday	225mcg		Dose increase
Tuesday		1	
Wednesday	225mcg		
Thursday		1	
Friday	225mcg		
Saturday		1	
Sunday		2	
Monday	275mcg		Dose increase

3. DeVante is titrating on his fentanyl patch, but has had many missed doses. He comes into the clinic on Thursday for a restart, after not presenting to the clinic for more than 7 days. He has the old patch on his skin, intact.

You discuss with the physician, and restart him at 50mcg. You instruct him to come back tomorrow (Friday) for his patch change.

DeVante comes in the next day, and you use the OSCAR fentanyl patch template to document how he is doing. You apply a new 50mcg patch to his skin and instruct him to return to the clinic Monday.

On Monday, you check in with him about his dose, and ask if he would like to go up. He is eligible to go up for the patch change, and he will have two patch changes since his last dose adjustment. He reports that he would like an increase, so you discuss with the physician, who writes a prescription for 100mcg to start on Wednesday's dose.

Day of the week	Patch change	Day Counter	Dose
Thursday	Restart at 50mcg	Has missed many days	50mcg
Friday	New Patch (same site as Thursday's patch)		50mcg
Saturday		1	
Sunday		2	
Monday	New Patch - ask him if he would like to go up on the next dose and discuss with the physician		50mcg
Tuesday		1	
Wednesday	New Patch - 1st opportunity to increase dose		100mcg
Thursday		1	
Friday	New Patch		100mcg
Saturday		1	

4. Andres comes into the clinic for his patch change on a Tuesday, and reports that he has lost his patch. You inspect his skin and he has no patches on his body.

This is considered a first time diversion. Remind Andres that if a patch falls off, he should come to the clinic immediately, and bring the patch with him for us to inspect.

The physician may determine the new dose based on the individual circumstances, or they can apply the missed dose protocol as if the last patch change did not occur at all. In this example, Andres received his patch on Friday, but as that patch was potentially diverted, the missed dose protocol would apply from Wednesday, the last time he received a patch that was still in situ at the following patch change.

Note in the Ongoing Concerns section of the chart "Fentanyl patch diversion x 1 (Date)".

You discuss with the physician, and restart Andres on 50mcg, and instruct him to come back on Friday for his next patch change. He is next eligible to go up on his dose on Monday, after two patch changes.

Day of the week	Patch Change	Day Counter	Dose
Tuesday	Restart titration New patch	Doesn't apply - diversion	50mcg
Wednesday		1	
Thursday		2	
Friday	Patch change Discuss with physician about dose adjustment		50mcg
Saturday		1	
Sunday		2	
Monday	New Patch - increased dose		100mcg

5. Amanda is on methadone 60mg and the fentanyl patch 250mcg. She would like to go up on both.

Explain to Amanda that she cannot go up on both medications at once. After discussion, she decides that she would like to go up on her fentanyl patch. After this, she needs at least 2 changes at this new dose before she can adjust any of her OAT, including methadone.

The fentanyl patch titration schedule is the slowest of all the OAT titrations. When someone is titrating their fentanyl patch, other OAT cannot also be titrated.

Day of the week	Patch Change	Day Counter	Dose
Wednesday	Patch Change - would like to go up - discuss with physician		250mcg
Thursday		1	
Friday	New Patch- increased dose		300mcg
Saturday		1	
Sunday		2	
Monday	Patch Change		300mcg
Tuesday		1	
Wednesday	Patch Change		300mcg This is the first day she can adjust her Methadone dose, as she has had 2 patch changes at 300mcg.
Thursday		1	
Friday	Patch Change		300mcg
Saturday		1	

Resources:

https://www.fraserhealth.ca/employees/student-practice-education/student-practice-news/medication-practice#.XHhQ0T-GqAw

https://www.albertahealthservices.ca/Assets/info/hp/ltc/if-hp-ltc-e-06a-opioid-patch-handling.pdf

This policy is updated frequently, for the most recent version, please contact sarah.foster@phs.ca

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