CMA Response:

Consultation on the Prescription Drug List: Naloxone

Health Canada – Prescription Drug Status Committee

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is helping physicians care for patients.

On behalf of its more than 83,000 members and the Canadian public, the CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and over 60 national medical organizations.

The Canadian Medical Association (CMA) is pleased to provide comment on the proposal by Health Canada[1] to revise the listing for naloxone on the Prescription Drug List (PDL) to allow the non-prescription use of naloxone, "when indicated for emergency use for opioid overdose outside hospital settings".

The CMA has over 83,000 physician-members. Its mission is helping physicians care for patients and its vision is to be the leader in engaging and serving physicians, and the national voice for the highest standards for health and health care.

The harms associated with opioids, which include prescription medicines such as oxycodone, hydromorphone and fentanyl, as well as illegal drugs such as heroin, is a significant public health and patient safety issue. Harms include addiction, diversion, overdose and death.

According to 2013 estimates[2], Canada has one of the highest per capita consumptions of prescription opioids in the world. In North America, about 5% of the adult population, and substantially higher rates for teens and young adults, reported non-medical opioid use in the previous year. This rate is higher than all other illegal drugs, with the exception of marijuana.[3]

Data on the harms caused by opioids are not collected systematically in Canada; however, practitioners have seen the significant impact of these drugs on their patients and to whole communities, including indigenous peoples. Opioid addiction rates from 43% to 85% have been reported in some indigenous communities.[4] [5] In Ontario, according to the Office of the Chief Coroner, opioid-related deaths nearly tripled from 2002 to 2010.[6]

Canada's physicians believe that Canada needs a comprehensive national strategy to address the harms associated with psychoactive drugs, whether illegal or prescription-based.[7] One component of this strategy is the prevention of overdose deaths and complications with appropriate medication and prompt emergency response.

For over four decades, naloxone (or Narcan®) has been used as a prescription drug for the complete or partial reversal of opioid overdoses. Naloxone counteracts the life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. The World Health Organization placed naloxone on its list of essential medications in 1983.

Physicians have been encouraged to identify patients who could benefit from the co-prescription of naloxone, along with opioids, when these are necessary. Increased risk for opioid overdose includes previous episodes of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.[8] [9]

More recently, with the increase in opioid overdoses, different provinces have created programs to increase access to naloxone outside of health care settings, such as "take-home naloxone programs". The experience in Canada and in other countries has been shown to have various benefits, including reducing overdose deaths.[10] [11] In Canada, naloxone has been administered through intramuscular or subcutaneous injection in these community-based programs, but in other countries it has also been available in a nasal spray form or in a pre-filled auto-injector format. Those that receive the naloxone kit are trained in the recognition of signs and symptoms of opioid overdose, in the administration of naloxone and first aid and in the need to call for medical follow-up.

In its 2015 policy on *Harms associated with Opioids and other Psychoactive Prescription Drugs*, the CMA supports the improvement of access to naloxone, particularly by individuals who are at a high risk of overdose as well as third parties who can assist a person experiencing an opiate-related overdose. The CMA also encourages the creation and scaling up of community-based programs that offer access to naloxone and other opioid overdose prevention tools and services. This would include training for health workers, first responders, as well as opioid users, families and peers about the prevention of overdose fatalities.[12] Also in 2015, the CMA approved a resolution supporting "the development and implementation of a national strategy on the use of naloxone".[13]

A report issued by the United Nations Office on Drugs and Crime and the World Health Organization supports making naloxone available to first responders as well as to people dependent on opioids, their peers and family members who are likely to be present when an overdose occurs.[14] Many other organizations, such as the Canadian Pharmacists Association, the American Medical Association and the American Public Health Association, are also supportive of enhanced access to naloxone in the community.[15] [16] [17]

The prescription status has been one of the barriers to increased access to naloxone. It is more likely that a family member, partner or friend would need to administer the naloxone in an overdose than the person who is prescribed the drug. Community-based programs have had to work with standing orders from prescribers. First responders, such as police officers and firefighters, should be able to carry and administer the drug, given they are often the first professionals to arrive at a scene where someone has overdosed.

According to Health Canada, the provinces and territories have collectively asked that the prescription status be re-evaluated. Health Canada has undertaken a Benefit-Harm-Uncertainty assessment of naloxone, and come to the following conclusions:

> *This assessment recommended that naloxone could safely be administered without the direct supervision of a physician if the person administering the drug has appropriate training.*

The main risks associated with the unsupervised use of the drug are:

- *the administrator may have difficulty filling the syringe and administering the drug under pressure in an emergency situation;*
- *the administrator may not seek professional care for follow-up of the patient after injection;*
- *chance of the patient relapsing since the effects of naloxone may only last for up to one hour depending on amount and type of opioid causing the overdose;*
- *that the patient may become very agitated and aggressive after coming out of the opioid depression (Acute Opioid Withdrawal Syndrome).*

These risks can be mitigated with appropriate training of the potential administrator before naloxone is distributed. The benefit of quickly responding to an overdose far outweighed these risks. Evidence from provincial take-home programs indicates that naloxone can be administered (intramuscularly or subcutaneously) by a layperson and its effects monitored successfully without practitioner supervision. Although an opioid overdose might be mistakenly diagnosed by a layperson, the injection of naloxone in a person not overdosing on an opioid will cause no serious harm.[18]

Various jurisdictions have delisted or are studying special conditions for the status of naloxone as a prescription drug, including Italy and some U.S. States.[19]

The CMA appreciates the opportunity to provide feedback on this important matter to physicians, and congratulates Health Canada in taking the initiative to make naloxone more accessible in the community; thereby helping to address the concerning levels of opioid overdoses in Canada.

CMA Recommendations:

That Health Canada proceed with the revisions to the listing for naloxone on the Prescription Drug List, to allow the non-prescription use of naloxone when indicated for emergency use for opioid overdose outside hospital settings. As outlined in Health Canada's assessment, the potential risks can be mitigated by well-designed community-based programs.

That Health Canada assess the option of licensing naloxone products that don't require training for intramuscular or subcutaneous injection, such as nasal sprays or automated handheld injectors (similar to epinephrine auto-injectors for use in serious allergic reactions), in order to further increase accessibility.

References

[1] Health Canada. *Consultation on the Prescription Drug List: Naloxone*. File number: 16-100479-342. January 14 2016. Ottawa. Available: http://www.hc-sc.gc.ca/dhp-mps/consultation/drug-medic/pdl_ldo_consult_naloxone-eng.php (accessed 2016 March 17).

[2] International Narcotics Control Board. *Narcotics drugs: estimated world requirements for 2013; statistics for 2011*. New York: United Nations; 2013. Available: https://www.incb.org/documents/Narcotic-Drugs/Technical-Publications/2012/NDR_2012_Annex_2_EFS.pdf (accessed 2016 March 17).

[3] Fischer B, Keates A, Buhringer G, et al. Non-medical use of prescription opioids and prescription opioid-related harms: why so markedly higher in North America compared to the rest of the world? *Addiction*. 2013;109:177-81.

[4] Chiefs of Ontario. *Prescription drug abuse strategy: 'Take a stand.' Final report*. Toronto: Chiefs of Ontario; 2010. Available: www.chiefs-of-ontario.org/sites/default/files/files/Final%20Draft%20Prescription%20Drug%20Abuse%20Strategy.pdf (accessed 2016 March 17).

[5] Health Canada. *Honouring our strengths: a renewed framework to address substance use issues among First Nations people in Canada*. Ottawa: Health Canada; 2011. Available: http://nnadaprenewal.ca/wp-content/uploads/2012/01/Honouring-Our-Strengths-2011_Eng1.pdf (accessed 2016 March 17).

[6] National Advisory Council on Prescription Drug Misuse. *First do no harm: responding to Canada's prescription drug crisis*. Ottawa: Canadian Centre on Substance Abuse; 2013.

[7] Canadian Medical Association. *Policy Document PD15-06 - Harms associated with opioids and other psychoactive prescriptions drugs*. Ottawa: The Author; 2015. Available: https://www.cma.ca/Assets/assets-library/document/en/policies/cma_policy_harms_associated_with_opioids_and_other_psychoactive_prescription_drugs_pd15-06-e.pdf (accessed 2016-March 17).

[8] National Opioid Use Guideline Group. *Canadian guideline for safe and effective use of opioids for chronic non-cancer pain*. Hamilton, ON: McMaster University; 2010. Available: http://nationalpaincentre.mcmaster.ca/opioid/ (accessed 2016 March 17).

[9] Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *MMWR Recomm Rep*. 2016;65(RR-1):1-49. Available: http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1er.htm?s_cid=rr6501e1er_w (accessed 2016 March 17).

[10] Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: Interrupted time series analysis. *BMJ*. 2013;346:f174. Available: http://www.bmj.com/content/bmj/346/bmj.f174.full.pdf (accessed 2016 March 17).

[11] Banjo, O, Tzemis, D, Al-Outub, D, et al. A quantitative and qualitative evaluation of the British Columbia Take Home Naloxone program. *CMAJ Open*, August 21, 2014;2(3) E153-E161. Available: http://cmajopen.ca/content/2/3/E153.full (accessed 2016 March 17).

[12] Carter CI, Graham B. *Opioid overdose prevention & response in Canada*. Policy brief series. Vancouver: Canadian Drug Policy Coalition; 2013. Available: http://drugpolicy.ca/solutions/publications/opioid-overdose-prevention-and-response-in-canada/ (accessed 2016 March 17).

[13] Canadian Medical Association. *Policy Resolution GC15-18 - National strategy on the use of naloxone. Ottawa: The Author;* 2015. Available: policybase.cma.ca/dbtw-wpd/CMAPolicy/PublicB.htm (accessed 2016 March 17).

[14] United Nations Office on Drugs and Crime / World Health Organization *Opioid overdose: preventing and reducing opioid overdose mortality*. Discussion Paper UNODC/WHO 2013. Available: http://www.unodc.org/docs/treatment/overdose.pdf (accessed 2016 March 17).

[15] American Medical Association. *AMA adopts new policies at annual meeting*. Press Release. New York, NY: Reuters; June 19, 2012. Available: http://www.reuters.com/article/idUS182652+19-Jun-2012+GNW20120619 (accessed 2016 March 17).

[16] Drug Policy Alliance. *American Public Health Association Policy Statement on Preventing Overdose Through Education and Naloxone Distribution*. New York, NY: Drug Policy Alliance; October 30, 2012. Available: http://www.drugpolicy.org/resource/american-public-health-association-policy-statement-preventing-overdose-through-education-a (accessed 2016 March 17).

[17] Canadian Pharmacists Association. *CPhA Welcomes Health Canada Move to Change Prescription Status of Naloxone*. News Release. January 14, 2016. Available: https://www.pharmacists.ca/news-events/news/cpha-welcomes-health-canada-move-to-change-prescription-status-of-naloxone/ (accessed 2016 March 17).

[18] Health Canada. *Consultation on the Prescription Drug List: Naloxone*. File number: 16-100479-342. January 14 2016. Ottawa. Available: http://www.hc-sc.gc.ca/dhp-mps/consultation/drug-medic/pdl_ldo_consult_naloxone-eng.php (accessed 2016 March 17).

[19] United Nations Office on Drugs and Crime / World Health Organization *Opioid overdose: preventing and reducing opioid overdose mortality*. Discussion Paper UNODC/WHO 2013. Available: http://www.unodc.org/docs/treatment/overdose.pdf (accessed 2016 March 17).