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Quarterly publication of the Mississippi Pharmacists Association | Spring 2019

inside

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Vol. XLIV, No. 1 | Spring 2019 | Growing stronger together at MPhA

In this issue...

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This emblem designates *Mississippi Pharmacist* is a member of the State Pharmaceutical Editorial Association, recognizing its high journalistic standards in endeavoring to keep its members well informed on all developments relative to the pharmaceutical profession.

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2018 Recipients of the "Bowl of Hygeia" Award


Ronda Lacey
Alabama


Dennis McAllister
Arizona


Cissy Clark
Arkansas


Debby Johnson
California


Catherine Jarvis
Colorado


Marghie Giuliano
Connecticut


Lisa Stonesifer
Delaware


Michael A. Moné
Florida


Sharon Sherrer
Georgia


Starlin Haydon-Greatting
Illinois


Bernadette Brown
Indiana


Mickey Cooper
Iowa


Brian Caswell
Kansas


Pat Mattingly
Kentucky


Nick LeBas
Louisiana


Betty J. Harris
Maine


Dixie Leikach
Maryland


David Sencabaugh
Massachusetts


Phil Hagerman
Michigan


The "Bowl of Hygeia"


Laura Schwartzwald
Minnesota


Ricky Cash
Mississippi


Gene Forrester
Missouri


Tricia Campbell
Montana


Angie Svoboda
Nebraska


Roseann Visconti
Nevada


Jennifer Towle
New Hampshire


Rupal Mansukhani
New Jersey


Michael Raburn
New Mexico


John Westerman, Jr.
New York


Davie Waggett
North Carolina


Robert Biberdorf
North Dakota


Dan Karant
Ohio


Don Ritter
Oklahoma


Penny Reher
Oregon


Richard Williams
Pennsylvania


Abigail Vazquez
Puerto Rico


Kelley Sanzen
Rhode Island


Robert Hubbard
South Carolina


Hugh Mack
South Dakota

Larry Calhoun
Tennessee

Carol Reagan
Texas

Darryl Wagner
Utah

Allen Huffman
Virginia

Linda Garrelts MacLean
Washington

Ivan Cephas
Washington DC

Charles "Laddie"
Burdette, Jr.
West Virginia

Brook DesRivieres
Wisconsin

Stephen Rogers
Wyoming

The Bowl of Hygeia award program was originally developed by the A. H. Robins Company to recognize pharmacists across the nation for outstanding service to their communities. Selected through their respective professional pharmacy associations, each of these dedicated individuals has made uniquely personal contributions to a strong, healthy community. We offer our congratulations and thanks for their high example. The American Pharmacists Association Foundation, the National Alliance of State Pharmacy Associations and the state pharmacy associations have assumed responsibility for continuing this prestigious recognition program. All former recipients are encouraged to maintain their linkage to the Bowl of Hygeia by emailing current contact information to awards@naspa.us. The Bowl of Hygeia is on display in the APhA History Hall located in Washington, DC.

PRESIDENT'S MESSAGE

Lauren Bloodworth
MPhA President

Greetings,

I hope that everyone is having a fantastic start to 2019! MPhA has been quite busy these first few months.

In case you missed it, our membership renewal process changed in January. We now have annual renewals due each January so if you haven't renewed for 2019 yet, I hope you will do so very soon! January also brought the start of the Legislative Session, and Brynna has been keeping our membership abreast of the issues affecting pharmacy through our monthly email newsletters. All of the state pharmacy organization presidents and Board of Pharmacy president met again, and we are continuing our work towards the common goal of pursuing provider status.

February saw two successful Mid-Winter Meetings in Jackson and Oxford with four hours of live continuing education offered. Pharmacy Day at the Capitol was another exciting day in February where many of our members participated in discussions with legislators regarding key pharmacy topics. A big thank you to Brynna for helping develop some tangible items to educate them about our great profession! On February 27, MPhA, along with pharmacy leaders across the state, were invited to participate in a Mississippi Division of Medicaid-Pharmacy Stakeholder "Year of Collaboration" Kickoff Meeting to discuss the future of pharmacy service reimbursement. Community Pharmacy Enhanced Services Network-USA (CPESN-USA) Executive Director, Troy Trygstad, presented to Medicaid leadership and the pharmacy stakeholders on the importance of pharmacists as members of the healthcare team. Terri Kirby, Director of Pharmacy at Medicaid, charged those in attendance to work together to develop proposals for how pharmacy services could be implemented. Medicaid will be hosting quarterly pharmacy stakeholder meetings throughout the remainder of the year.

Our nominations for officers and various MPhA awards are currently being accepted this month. We will have an election for the office of treasurer and one member-at-large position which are both two year terms. Hopefully you've received the email or seen on social media the description for the officer positions and annual awards. Please email or call the office by April 1 to nominate someone deserving! You will also be receiving a proposed Bylaw amendment document prior to the Annual Convention. The proposal will be voted on at the business meeting held at the Annual Convention, and then an electronic ballot will be mailed after the Convention if the proposal is passed by two-thirds at the business meeting.

An exciting new continuing education offering is currently in the works. We are collaborating with MSHP to offer a joint MPhA-MSHP Fall Seminar and Residency Showcase scheduled for October 2019 with four hours of live continuing education in the morning followed by a Residency Showcase in the afternoon in Jackson. Stay tuned for further details!

Our Annual Convention will be on June 16-20, 2019, at the Sandestin Hilton. Registration is now open so we hope that you will all join us for 10 hours of live CE, lots of great networking opportunities, the exhibitor trade show, and some amazing fun in the sun!

All the best,
Lauren

CONGRATULATIONS

2018
Bowl of Hygeia Recipient

RICKY CASH
Grenada, MS

THE BOWL OF HYGEIA AWARD PROGRAM WAS ORIGINALLY DEVELOPED BY THE A. H. ROBINS COMPANY TO RECOGNIZE PHARMACISTS ACROSS THE NATION FOR OUTSTANDING SERVICE TO THEIR COMMUNITIES. SELECTED THROUGH THEIR RESPECTIVE PROFESSIONAL PHARMACY ASSOCIATIONS, EACH OF THESE DEDICATED INDIVIDUALS HAS MADE UNIQUELY PERSONAL CONTRIBUTIONS TO A STRONG, HEALTHY COMMUNITY.

Welcome New Members!

Leigh Beaty
Dustin Cantrell
Joyce Folse
Michael Gallotte
Christina Hansen
Jillianne Hiller
Jeffery Jones
Samantha Lewis
Tran Nguyen
Joseph Serio
Katie Shackelford
Trina Stewart
Okoia Stoddard
Sandra Stroehman
Meredith Wagner
Alexandra White

SHARE YOUR PHARMACY STORY

Want to share what happens for a day at your pharmacy on our social media? Do you know a pharmacist who has a story that needs to be highlighted in our Journal ? Well, the Mississippi Pharmacists Association is looking for pharmacy stories to share. MPhA is one of the oldest pharmacy associations in the nation, and we want to give the opportunity to make sure everyone's pharmacy story is seen by everyone. Contact us on how to make to this happen today!

CONTACT INFORMATION

INFO@MSPHARM.ORG OR AMANDA@MSPHARM.ORG

CHRISTMAS PARTY

Thursday, December 6, 2018

sponsored by

CardinalHealth

On December 6th, 2018, MPhA held the annual Christmas Party at Drago's Seafood in Jackson. We had great success for our Toys for Tots Drive, with the floor and table stacked high with toys. Thank you to everyone who could come out and make it, and especially to Cardinal Health for their sponsorship.

A day without a Pharmacy Techn

by Stephanie Jones, CPhT, B.S., MEd.

Imagine walking into work and knowing that your lead, head, or top technician will not be there. Do you feel a sense of dread? If you're a relief pharmacist and you're walking into an unfamiliar pharmacy, and you're the only pharmacist, do you ask if the lead technician will be there? Would you dare step in and work without having the technician or technicians that know the computer system and know how things run smooth? Who trains the new technicians? Do your technicians train the new employees, or does the pharmacy director take on the responsibility? Take a moment and think what your day would be like without a pharmacy technician.

I am not saying you could not run a pharmacy without a technician, because let's face it; we all know that a pharmacy technician is under the supervision of a pharmacist. I want everyone to take note of how vital technicians are today in a pharmacy. The Pharmacist relies more and more on technicians to help lighten their workload. Technicians are the backbone of every pharmacy and are tackling an increasing workload. The Mississippi Board of Pharmacy changed the ratio of technicians per pharmacist to 3:1. Also, under new regulations, a Pharmacy Technician in an institutional setting may conduct patient medication histories without the direct supervision of a pharmacist. The institution must have policies, procedures, and training protocols to govern such tasks which went into effect on February 15th, 2019. Allowing technicians to be involved in

medication reconciliation will likely lower medication errors. According to The Joint Commission and the Institute for Safe Medication Practices (ISMP), the need to carefully document medication therapy throughout a patient's treatment process within an institutional stay from admission to discharge is vital. When a patient is moved from one care unit to another, many people are involved, and there is an increase in medication errors. The purpose of allowing technicians to be required in medication reconciliation is intended to identify and resolve discrepancies in the process of comparing the medications a patient is taking and what the patients should be taking.

There are some upcoming changes for pharmacy technicians who want to become certified. In the state of Mississippi, a technician may become certified by taking the PTCE or ExCPT exam. According to the Pharmacy Technician Certification Board (PTCB) starting in 2020, PTCB, the nation's leading certifying organization for pharmacy technicians, will change its eligibility requirements for the Certified Pharmacy Technician (CPhT) Program and update its Pharmacy Technician Certification Exam (PTCE). PTCB will offer two eligibility pathways for technicians submitting certification applications beginning January 1, 2020. One will be the completion of a PTCB-recognized education/training program, and the other will be equivalent work experience.

The ExCPT is a nationally accredited certification exam offered by the National Healthcareer Association (NHA). According to the National Pharmacy Technician Association (NPTA) to be eligible to sit for the ExCPT exam, a technician must be within no more than 30 days of successful completion of all requirements needed to obtain a high school diploma or the GED/high school equivalent. Or, complete a training program or military training or have relevant work experience.

I have taught at Jones College for 16 plus years, and I have come in contact with many pharmacists that recognize the importance of a technician. Many local pharmacies have requested a graduate of our program and have stated they will not hire a technician unless they have come through our program. One pharmacist commented that it was a relief to have a technician that can go in now "work ready" without having to train them and they can focus their attention on counseling their patients and medication safety.

My colleague that I work, with has been a pharmacist for over 20 years and when she started teaching the Pharmacy Technology program, she stated that she had no idea how much a student learns and how much information in detail they learn until she began teaching the courses. Technicians that have gone through our accredited program receive an associate's degree in applied science and are taught Dosage Calculations, Pharmacology, Pharmacy Practice, Pharmacy Law, Pharmacy Fundamentals, Nonprescription Drugs, Management, Computer Applications in Pharmacy, Pharmacy Anatomy and Physiology, Drug Information Research, Pharmacy Transition, Pharmaceutical Compounding, and 3 semesters of Practicum I, II, III which involve clinical experience with a total of 516 hours. Each graduate of our program is encouraged to take the PTCE exam, which is highly favored among pharmacist and other states. We have a very high success pass rate with PTCE. Once students graduate, many become lead technicians and become mentors for our current students or further their education and become pharmacists. While students are enrolled in pharmacy school, they will work as a technician while pursuing their journey to become a pharmacist.

The demands and roles of a pharmacist are evolving more and more each day, and they depend more on technicians. With the upcoming changes to become a certified technician, seeing the value and worth of a pharmacy technician and working together as a team can make a day go by smoothly and will make any pharmacist not want to go "A day without a Pharmacy technician."

Stephanie Jones, CPhT, B.S., MEd.
Pharmacy Technology Instructor
Jones College, 900 South Court Street
Ellisville, MS 39437; 601-477-4230;
stephanie.jones@jcjc.edu

MID-WINTER MEETINGS

Jackson and Oxford

The MidWinter meetings were held in February in Oxford and Jackson. CE topics included a Government Affairs/PAC update and a Board of Pharmacy update from Director of Compliance, Cheri Atwood, and Compliance Agent, Sid Seal. Terri Kirby, Pharmacy Director of Mississippi Medicaid also presented on Medicaid. Assistant Professor of Psychiatry at the University of Mississippi Medical Center Dr.Saurabh Bhardwaj shared a presentation on the Innovations in Medication-Assisted Treatment for Opioid Use Disorder. Attendees received four hours CE including fulfilling their live CE requirements.


NIVERSITY of
SSISSIPPI

Anna Touchstone

Pharm.D. Student, Year 3

UM School of Pharmacy

WHAT TYPE OF PHARMACY DO YOU PLAN TO PRACTICE AND WHY?

I'm still not certain of what career path I plan to pursue. During my time in school and on rotations, I have developed an interest for more non-traditional pharmacy paths. I plan to use the upcoming year of rotations to see as many settings in pharmacy as I can to help guide me towards a decision!

WHY IS AN MPHA MEMBERSHIP IMPORTANT?

Mississippi as a state suffers in many health-related areas, including having some of the highest rates of heart disease and diabetes in the nation. This characteristic makes pharmacy a vital part of the healthcare system here by being an accessible form of healthcare for a population that is also among the poorest in the nation. MPhA has the potential to be a model for the rest of the country as an association. Mississippi is a small state, and pharmacy is a small world. I think every pharmacist in Mississippi should join MPhA, because it gives the perfect opportunity for us all to come together in a safe and loving environment, made up of our friends, family, neighbors, and classmates, to share our ideas and knowledge to help make Mississippi a better place for our patients.

HOW HAS BEING A MEMBER OF MPHA HELPED YOU PROFESSIONALLY?

The annual convention I attended as a P1 was my first ever meeting to attend as a student. During that meeting, I was given the opportunity to network with Mississippi pharmacists, learn from them, and gain inspiration for my own career. Since that meeting, I had the opportunity to travel to many meetings and grow as a professional and a future pharmacist. I love the atmosphere that MPhA gives me to be able to connect with people in the profession. I have truly grown and come out of my shell over the past 3 years, with the help of MPhA.

IF YOU COULD CHANGE SOMETHING ABOUT THE PROFESSION, WHAT WOULD IT BE?

The training we go through to become pharmacists is very rigorous. As medication experts, we are expected to assist physicians regarding each patient's medication needs. Even though pharmacists have a Doctor of Pharmacy degree, pharmacy is still an unappreciated profession. I hope to use my career to help move pharmacy forward into an age where we are respected as professionals and appreciated as healthcare providers.

WHAT IS YOUR FAVORITE CLASS IN SCHOOL AND WHY?

I love our Problem Based Learning classes. I think it is so much easier to learn about drugs, how they work, and how they affect patients when we are given a case that gives us a real-life scenario. The cases give us a chance to walk through everything slowly and make connections with the information. It also gives us the opportunity to work in teams, which I always enjoy!

I STILL WANT TO...

…gain confidence in myself. Something I still struggle with is second-guessing myself and my ability to make a decision on my own, whether for an organization or when choosing therapy for a patient case. I am looking forward to the coming year of rotations as a chance to push myself to be confident in the knowledge I have gained and know that I have the ability to make a positive difference in my patients' lives.

WHAT TYPE OF PHARMACY DO YOU PLAN TO PRACTICE AND WHY?

I was drawn to pharmacy because of the human element. I wanted to make medicine with my own two hands for another person's benefit. Once I started pharmacy school I began to realize that my aspirations were growing from wanting to help one person at a time to wanting to help a community at a time. I am very interested in clinical pharmacy, because I want to develop interprofessional partnerships and gain as much clinical experience that I can. In order to do so, I plan to start off with a residency, find a clinical position, and then translate my experience into streamlining patient centered care through IT pharmacy.

WHY IS AN MPHA MEMBERSHIP IMPORTANT?

Joining MPhA is absolutely essential if your goals truly are to improving patient care in this state. Being a part of MPhA is a networking lifeline to APhA, which helps us to show other states when we have figured out a good solution to a common problem, and vice versa. You have to adjust your lens- do you want to work in the field as is, or do you want to help improve it while you're at it? Not one of us can make large scale change happen, but when we network and share ideas, we can help our state, and then we can use our experience in our state to help someone else's. We have to trust each other and recognize that we are all valuable, but that together we can be even more than that.

HOW HAS BEING A MEMBER OF MPHA HELPED YOU PROFESSIONALLY?

I am looking forward to the annual convention this summer. It offers the perfect opportunity to network across the state with like-minded individuals and build long lasting relationships with other people who do not see pharmacy as just a job, but as a lifelong profession and identity. I am very excited to learn everything I can and build mental connections, bridging what I am learning as a student with what I will be doing as a pharmacist.

IF YOU COULD CHANGE SOMETHING ABOUT THE PROFESSION, WHAT WOULD IT BE?

I would love to see pharmacists have prescriptive authority for dose adjustment for previously diagnosed conditions and previously ordered medications, as well as the authority to extend refills. While we maintain professional competency in this area, we are not able to utilize it effectively to get a patient on track at the moment that we see an issue, because we lack the authority to do so. I believe this issue also extends to situations in which drug-drug, drug-allergy and drug-condition interactions arise. In the 1960s the courts began holding pharmacists accountable for mistakes surrounding these issues, so I would like to see our liability match up with our ability to prevent these types of errors. My solution? The pharmacist should be able to use his/her judgement to change an offending prescription to an appropriate one, fill it and inform the doctor about the change. Convenience breeds efficiency, which gives us more time to provide true patient centered care.

WHAT IS YOUR FAVORITE CLASS IN SCHOOL AND WHY?

We have a class called Service Learning. It is my absolute favorite, as the majority of the time we are out of the classroom and in our communities doing a variety of activities that all have one thing in common: serving with compassion. We had an activity last term in which we did presentations with middle schoolers about mental health. After the presentation I was able to set up a training program at no cost to the school to help them train their staff in identifying at risk kids, and what to do to help them, as well as a free resource period in which the kids can come once a week to get help. Service Learning gave me the opportunity to connect with my community in a meaningful way, and I feel strongly that that is what pharmacy is all about.

I STILL WANT TO...

…Learn, learn, learn! I am still learning what my role is in the healthcare team, and how to put patients first without stepping on any toes. I very much look forward to my IPPEs and APPEs, and the opportunities therein to make connections, stay informed, and become the best pharmacist I possibly can.

Colleen McNulty

Pharm.D. Student, Year 1

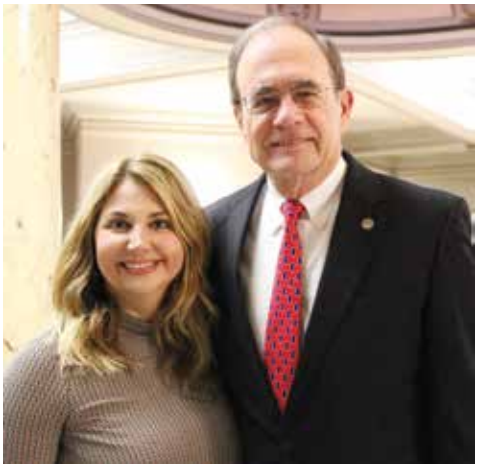
WC

PHARMACY DAY at the CAPITOL

Thursday, February 21, 2019

sponsored by

APCI
American Pharmacy
COOPERATIVE, INC.



Pharmacy Day at the Capitol, sponsored by the American Pharmacy Cooperative, Inc (APCI), was Thursday, February 21st. The Mississippi Board of Pharmacy, MPhA, MIPA, MSHP and students from the University of Mississippi and William Carey University represented the profession. Student pharmacists conducted health screenings and pharmacists advocated to legislators. We hope you will join us again next year on January 30, 2020 for Pharmacy Day at the Mississippi State Capitol.


Pharmacy Day at the Capitol
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MSHP
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Thank you to our MPhA PAC Donors !

Leigh Beaty
Ronnie Cannon
Richard Cash
Howard Christian
Judith Clark
Joshua Daniel
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Rhonda Dunaway
Ann Franklin
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Max Sanders
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**As of December 2018- March 2019*

Mississippi Pharmacy FOUNDATION

Donations to the Mississippi Pharmacy Foundation support pharmacy student scholarships, educational programs, and facility improvements and maintenance. Contributions to this 501(C)(3) organizaion are deductible as charitable donations for federal income tax purposes.

Thank you for contributing to the future of pharmacy!

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Rhonday Dunaway, Biloxi
Ann Franklin, Cleveland
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Karen Sullivan, Hattiesburg
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**As of December 2018- March 2019*


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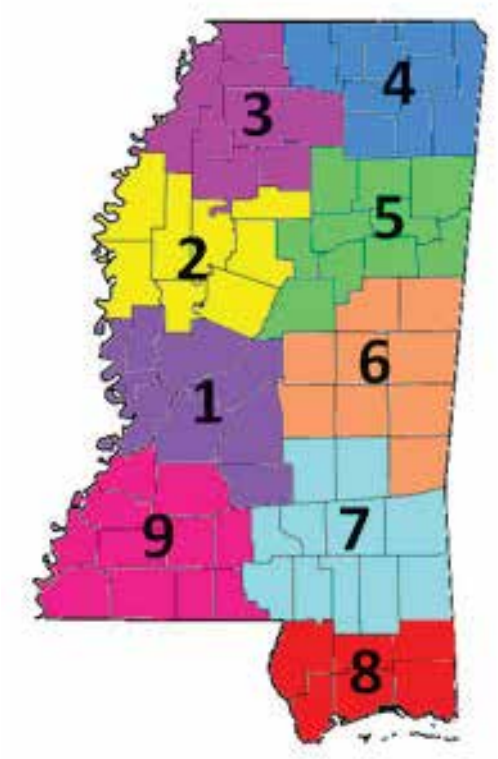
Ends May 18th

District 8 Meeting

Tuesday, Feburary 12th at Patio 44 in Long Beach

MPhA District Chairs



District 1
Co-Chair: Emily Melton Bond
Brandon, MS
Co-Chair: Tera McDivitt
Brandon, MS

District 2
Chair: John Downs
Greenwood, MS

District 3
Chair: Val Soldevila
Clarksdale, MS

District 4
Chair: Jonethan Morris
Rienzi, MS

District 5
Chair: Eddie Rutherford
Kosciusko, MS

District 6
Chair: Logan Davis
Meridian, MS

District 7
Chair: Kristi Nesler
Sumrall, MS

District 8
Chair: Chris Ayers
Ocean Spring, MS

District 9
Chair: Sam Daniel
McComb, MS

Email us at info@mspharm.org to get connected with your District Chair!

What District Do You Live In?

DISTRICT 1

Counties	Cities
Hinds	Clinton, Jackson, Raymond, Byram, Bolton, Edwards, Terry, Utica
Issaquena	Mayersville
Madison	Madison, Ridgeland, Canton, Gluckstadt
Rankin	Brandon, Flowood, Pearl, Richland, Pelahatchie, Puckett, Florence
Sharkey	Rolling Fork, Anguilla, Cary
Simpson	Magee, Mendenhall, D'Lo
Warren	Vicksburg
Yazoo	Yazoo City, Benton

DISTRICT 3

Counties	Cities
Coahoma	Clarksdale
Desoto	Olive Branch, Hernando, Southaven, Horn Lake
Lafayette	Oxford, Abbeville, Taylor
Panola	Batesville, Como, Sardis
Quitman	Marks
Tallahatchie	Charleston, Sumner, Tutwiler, Webb
Tate	Senatobia, Coldwater
Tunica	Tunica
Yalobusha	Water Valley, Oakland, Tillatoba, Coffeeville

DISTRICT 5

Counties	Cities
Attala	Kosciusko, Ethel, McCool, Sallis
Calhoun	Calhoun City, Bruce, Derma, Vardaman
Chickasaw	Houston, Okolona
Choctaw	Ackerman, French Camp, Weir
Clay	West Point
Lowndes	Columbus, New Hope, Caledonia, Artesia, Crawford
Monroe	Aberdeen, Amory, Nettleton
Montgomery	Winona, Kilmichael, Duck Hill
Oktibbeha	Starkville, Sturgis
Webster	Stewart, Eupora, Mathiston, Maben

DISTRICT 7

Counties	Cities
Covington	Collins, Mount Olive, Seminary
Forrest	Hattiesburg, Petal
Greene	Leakesville, McLain, State Line
Jasper	Bay Springs, Heidelberg, Stringer
Jeff. Davis	Bassfield, Prentiss
Jones	Laurel, Ellisville
Lamar	Lumberton, Purvis, Sumrall
Marion	Columbia, Sandy Hook
Perry	Beaumont, New Augusta, Richton
Smith	Taylorsville, Mize, Raleigh
Wayne	Waynesboro

DISTRICT 2

Counties	Cities
Bolivar	Cleveland, Rosedale, Mound Bayou, Shaw, Shelby
Carroll	Carrollton, North Carrollton, Vaiden, McCarley
Grenada	Grenada
Holmes	Durant, Lexington, Cruger, Goodman, Pickens, Tchula, West
Humphreys	Belzoni, Isola, Louise, Silver City
Leflore	Greenwood, Itta Bena, Morgan City, Sidon, Schlater
Sunflower	Indianola, Drew, Moorhead, Ruleville, Doddsville, Inverness, Sunflower
Washington	Greenville, Hollandale, Leland, Towns, Arcola, Metcalfe

DISTRICT 4

Counties	Cities
Alcorn	Corinth, Rienzi
Benton	Ashland, Hickory Flat, Snow Lake Shores
Itawamba	Fulton, Mantachie, Tremont
Lee	Tupelo, Baldwyn, Verona, Saltillo, Shannon
Marshall	Holly Springs, Byhalia, Potts Camp
Pontotoc	Pontotoc, Ecru
Prentiss	Booneville, Jumpertown, Marietta
Tippah	Ripley, Blue Mountain, Dumas, Walnut, Falkner
Tishomingo	Iuka, Belmont, Burnsville, Golden, Tishomingo
Union	New Albany, Myrtle, Blue Springs

DISTRICT 6

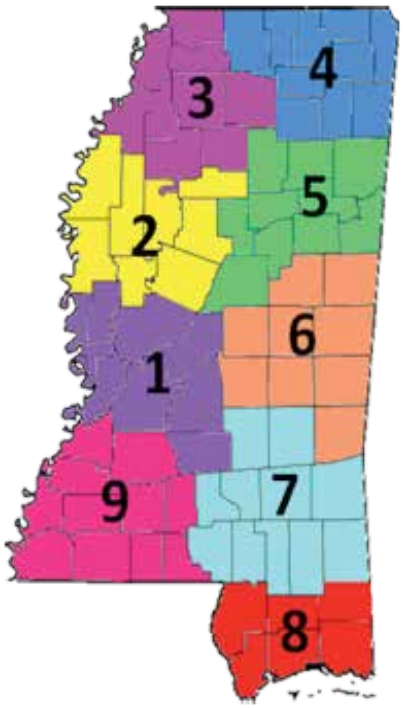
Counties	Cities
Clarke	Quitman, Enterprise
Kemper	Dekalb, Scooba
Lauderdale	Meridian, Marion
Leake	Carthage
Neshoba	Philadelphia
Newton	Newton, Union
Noxubee	Macon, Brooksville, Shuqualak
Scott	Forest, Morton, Lake, Sebastapol
Winston	Louisville, Noxapater

DISTRICT 8

Counties	Cities
George	Lucedale
Hancock	Bay St. Louis, Waveland, Diamondhead, Kiln
Harrison	Biloxi, D'Iberville, Gulfport, Long Beach, Pass Christian, Lyman, Saucier
Jackson	Vancleave, Gautier, Moss Point, Ocean Springs, Pascagoula
Pearl River	Lumberton, Picayune, Poplarville
Stone	Wiggins, Perkinston

DISTRICT 9

Counties	Cities
Adams	Natchez
Amite	Gloster, Liberty
Claiborne	Port Gibson
Copiah	Crystal Springs, Georgetown, Hazlehurst, Wesson
Franklin	Bude, Meadville, Roxie
Jefferson	Fayette
Lawrence	Monticello, New Hebron, Silver Creek
Lincoln	Brookhaven
Pike	Magnolia, McComb, Osyka, Summit
Walthall	Tylertown
Wilkinson	Centreville, Crosby, Woodville



4 TIPS TO RENEWING YOUR MEMBERSHIP

At the beginning of 2019 MPhA switched over to a new calendar year renewal process. Here are four tips to help you remember when you're membership is up for renewal!

1.Call us!

We're here to answer your questions.

Unsure about when the last time you have have renewed with us? Give us a call at *601-981-0416*, we will gladly help you figure everything out to make sure your membership is still valid!

2.Email us!

Too busy to make a call? Then send us an email!

Forgot your login information? Can't remember your password to your MPhA member account? Send us an email at *Membership@mspharm.org* with your login issues and we can reset your information for you!

3.Set A Reminder!

Renewals will now always be due in January of every year.

Set an annual reminder on your phone calendar so you'll always know when it is time to renew your MPhA membership!

4.Receive our emails!

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Lucemyra™ an Oral Agent to Facilitate Abrupt Opioid Withdrawal

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BACKGROUND

The use of opioids to control pain is a common occurrence around the world. An estimated 58.5 prescriptions per 100 persons are prescribed in the US.[1] These numbers do not include the use of opioids that are illegally diverted or illicit entities such as heroin. In 2017, there were a total of 3,302,879 opioid prescriptions written in Mississippi. This equates to 110.5 opioid prescriptions per 100 persons in Mississippi, and it would allow each person in Mississippi to have one opioid prescription in the year 2017. There were 256 suspected overdose-related deaths in Mississippi in 2017. Of those deaths, opioids accounted for 67.6% of deaths and prescription opioids accounted for 32.4% of overdose deaths in 2017.[7] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) now includes Opioid Use Disorder (OUD) which is categorized by the habitual self-administration of opioids for long periods of time as well as other criteria. Please see Table 1 for DSM-5 diagnostic criteria for Opioid Use Disorder.[2] Patients can be diagnosed with mild (2-3), moderate (4-5), or severe (6 or more) OUD based on the amount of diagnostic symptoms patients have, up to a maximum score of 11 on the scale. Opioid withdrawal can be seen in patients with OUD, chronic opioid use, as well as those on agonists/antagonist therapy that has been abruptly discontinued.

TABLE 1[2]

DSM-5 Diagnostic Criteria of Opioid Use Disorder	
Patients must meet at least 2 of the following symptoms within a 12 month period to be diagnosed	
• Opioids are often taken in larger amounts or over a longer period than was intended • There is a persistent desire or unsuccessful effort to cut down or control opioid use. t • A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects. • Craving, or a strong desire or urge to use opioids. • Recurrent opioid use resulting in a failure to fulfil major role obligations at work, school, or home. • Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids. • Important social, occupational, or recreational activities are given up or reduced because of opioid use.	• Recurrent opioid use in situations in which it is physically hazardous. • Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. • Tolerance, as defined by: a.) A need for markedly increased amounts of opioids to achieve intoxication or desired effect; or b.) A markedly diminished effect with continued use of the same amount of an opioid. • Withdrawal, as manifested by: a.) The characteristic opioid withdrawal syndrome; or b.) Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms
Specifiers	
• Early Remission – patient previously met criteria for diagnosis and now meets none of them for at least 3 months but for less than 12 months (may still meet the craving, or strong desire or urge to use criteria). • Sustained Remission – patient previously met criteria for diagnosis and now meets none of them for 12 months or longer. (may still meet the craving, or strong desire or urge to use criteria).	• On Maintenance Therapy – patient is currently being prescribed an opioid agonist/antagonist medication and does not meet any criteria except for possible tolerance to or withdrawal from agonist. • In Controlled Environment – patient is in an environment where opioids are restricted.

The American Society of Addiction Medicine (ASAM) proposes that there are two approaches for opioid withdrawal management. The first option is to wean patients slowly off of opioids with opioid agonist or antagonist therapy such as methadone, buprenorphine, or naltrexone over a period of 3 to a maximum of 30 days depending on which agent is used. The caveat to using methadone is that no retail pharmacy can legally dispense methadone for the indication of maintenance of addiction and withdrawal. Only licensed treatment facilities may dispense methadone for this indication. However if a patient cannot be weaned from opioids due to intentional or unintentional abrupt discontinuation, the treatment of opioid withdrawal symptoms is needed.[3] Signs that are usually present in opioid withdrawal and the medications currently used to treat those symptoms are in Table 2.[4] There are three scales the ASAM suggests to use in the determination of withdrawal symptoms; OOWS (objective opioid withdrawal scale), SOWS (subjective opioid withdrawal scale), and COWS (clinical opioid withdrawal scale). The COWS score may be the preferred option of the three by including both subjective and objective information into the scoring.[3] By utilizing these scores, prescribers can treat patients withdrawal symptoms based on the responses of the patient and withdrawal severity. For an example of the Clinical Opioid Withdrawal Scale see Table 3.

LUCEMYRA

Lucemyra, approved on May 16, 2018, is the first non-opioid medication approved in the United States for the management of opioid withdrawal symptoms. Each tablet contains 0.18 mg of active drug (lofexidine hydrochloride) and is a central acting alpha-2 adrenergic agonist. Lofexidine binds to the adrenergic neuron receptors and down-regulates the release of norepinephrine and decreases sympathetic tone. It is well absorbed

by mouth with an absolute bioavailability of 72%, and it reaches peak plasma concentration around 3 to 5 hours after one dose. The half-life is around 12 hours with around 30% of the drug being metabolized by first pass metabolism in the gut. The liver also plays a part in metabolism with the enzyme CYP2D6. The major route of elimination is via the kidneys with around 20% being excreted unchanged.

INDICATIONS AND DOSING

Lofexidine is indicated for the alleviation of opioid withdrawal symptoms in the sudden discontinuation of opioids in adults. Dosing in patients with no renal or hepatic impairments is three 0.18 mg tablets by mouth four times daily during peak withdrawal symptoms. Five to six hours should elapse between each dose and no more than 2.88 mg or sixteen tablets should be given in a day (four tablets per dose maximum). Lofexidine therapy can be continued for up to fourteen days as long as symptoms persist. Doses should be adjusted based on symptoms from the drug or the withdrawal. For example, if a patient cannot tolerate three tablets, two tablets should then be administered instead. Inversely, if a patient is still having withdrawal symptoms with three tablets, four tablets should be administered with the next dose. There are no dose adjustments when taken with or without food. For dosing in patients with renal or hepatic failure, see Table 4[6].

CONTRAINDICATIONS, WARNINGS, AND PRECAUTIONS

Lofexidine is not contraindicated in any patient population currently but should be used with precaution in those with certain conditions. In individuals suffering from cardiovascular disorders such as hypotension, bradycardia, syncope, or QT prolongation, the use of lofexidine should be under the supervision of health care providers or outpatient only with persons capable of self-monitoring. Lofexidine can also increase the risk of CNS depression with the concomitant use of drugs like benzodiazepines, barbiturates, alcohol, and other sedating drugs. Those being treated for opioid withdrawal are at a higher risk of an overdose after discontinuation of an opioid due to reduced tolerance. A referral to a program that helps with opioid use disorders should always come with the use of lofexidine and patients/caregivers must be informed about this risk when starting the medication. Lofexidine should never be suddenly stopped without speaking to their health care provider due to rebound symptoms such as increased blood pressure, diarrhea, insomnia, anxiety, chills, hyperhidrosis, and peripheral pain. The package insert suggests discontinuation over a two to four day period by reducing a tablet each dose every one to two days. Lofexidine has been studied for interactions with methadone, buprenorphine, naltrexone, and paroxetine. The only significant drug interaction that was seen was with paroxetine, which increased lofexidine concentrations by 11%-28%. Because of this interaction caution should be used when lofexidine is given with CYP2D6 inhibiting drugs like paroxetine due to the increased risk of hypotension and bradycardia. The use of lofexidine in pregnant, lactating, pediatric, or geriatric populations have not been established so a risk over benefit evaluation should be assessed before starting lofexidine.

EFFICACY

Two randomized, double-blind, placebo-controlled trials were conducted to test the efficacy of lofexidine. The first study, NCT 01863186, was a two-part study conducted in the United States. The

TABLE 2

Common Drugs Used In Withdrawal	Typical Dose And Frequency	Signs and Symptoms Being Treated
Clonidine – off-label use	0.1 – 0.2 mg/dose PO two to four times daily (Max of 1.0 mg/day)	Tachycardia and Hypertension; Sympathetic overactivity: lacrimation, piloerection, yawning, diaphoresis; Mydriasis
Ondansetron	8 mg PO three times daily	Nausea and Vomiting
Phenergan	12.5 – 25 mg IM, may repeat in two hours OR 25 mg IM initially, then 12.5 – 25 mg every 4 – 6 hours	
Loperamide	4 mg PO, then 2 mg PO after each loose stool up to 16 mg/day	Diarrhea
Bismuth Salicylates	524 mg PO every 30 to 60 minutes up to 8 doses/day for no more than 2 days	
Benzodiazepines (Diazepam)	2 – 10 mg IM/IV every 3 to 4 hours	Anxiety and Excitability
Diphenhydramine	10 – 50 mg IM/IV every 2 to 4 hours (Max of 400 mg/day) OR 25 – 50 mg PO every 4 to 6 hours	Rhinorrhea
Hydroxyzine – off-label use	50 mg PO three times daily	
Acetaminophen	650 mg PO every 4 to 6 hours (Max of 4 g/day)	Myalgias
NSAIDs	Ibuprofen: 400 mg PO every 4 to 6 hours up to 3,200 mg/day Naproxen: 500 mg PO (550 mg naproxen sodium) every 12 hours up to 1,000 mg/day (1,100 mg/day naproxen sodium) Ketorolac: 10 mg PO initial (<50 kg) or 20 mg PO initial (>50 kg) followed by 10 mg PO every 4 to 6 hours up to 40 mg/day	
Trazadone – off-label use	50 – 100 mg PO at bedtime (Max of 600 mg/day)	Insomnia
Dicyclomine	20 mg PO four times daily	Abdominal Cramps
Other symptoms noted: drug cravings, yawning, and seizures which can be treated by various means		

patients in this study were physically dependent (based on DSM-IV criteria) to short-acting opioids. The first part was an inpatient design that lasted 7 days and patients were given one of three treatments: 229 patients received lofexidine 2.16 mg daily (0.54 mg four times a day), 222 patients received 2.88 mg daily (0.72 mg four times a day), and 151 patients received a placebo. Patients also were also allowed to have support medications for withdrawal symptoms. The patients that completed the first 7 days were able to then receive lofexidine for 7 more days and the dose determined by the investigator but did not exceed 2.88 mg daily. The study proved efficacy in comparison to placebo based on the average of the total Short Opiate Withdrawal Scale of Gossop (SOWS-Gossop)[5] patients reported and the percentage of patients that completed 7 days of treatment. The SOWS-Gossop scale is on a 0 to 30 range, 30 representing the most severe withdrawal symptoms and 0 representing no symptoms present. The average scores for the placebo group were 8.8 while the lofexidine 2.16 mg group and 2.88 mg group averaged 6.5 and 6.1 respectively. Both the lofexidine groups had a statistically significant difference in the mean SOWS-Gossop scores throughout the 7 days.[6] The data also showed that 28% of placebo patients, 41% of 2.16 mg patients, and 40% of 2.88 mg patients completed the 7 days.

The second study, NCT 00235729, was an inpatient study conducted throughout multiple hospitals across the United States and used patients that were physically dependent (based on DSM-IV criteria) to short-acting opioids. Patients in this study were randomly put into two groups: 134 were given lofexidine 2.88 mg per day (0.72 mg four times a day) and 130 in the placebo group. Both groups were given treatment for five days and were allowed support medications for symptoms. On days 6 and 7 of the study, all patients were given the placebo and discharged on day 8 of the study. The endpoints of this study were evaluated like the previous study with both a SOWS-Gossop mean score and the percentage of patients that completed the course of therapy. Out of the groups, 49% of the lofexidine group and 33% of the placebo group completed therapy. The difference of both the percentages and mean SOWS-Gossop scores were statistically significant.[6] Both studies proved efficacy when compared to placebo in the treatment of short-acting opioid withdrawal symptoms.

CONCLUSION

Lofexidine is the first of its kind, FDA approved medication in the United States to combat opioid withdrawal symptoms in rapid discontinuation and can have a unique place in therapy when used correctly. Lofexidine is usually only required for 7 days of treatment in patients but can be prescribed by a physician for up to 14 days, but the treatment timeline will vary between patients based on symptoms that the patient is having. Opioid withdrawal can happen in many different patients so it is important to know the signs and symptoms of withdrawal and the medications that can be used to counteract them. With more than

TABLE 3[8]

Clinical Opiate Withdrawal Scale Example	
Resting Pulse Rate: _____beats/ min (Measure after patient is sitting or lying for one minute.) 0: pulse rate 80 or below 1: pulse rate 81-1 00 2: pulse rate 101-120 4: pulse rate greater than 120	GI Upset: over last 1/2 hour 0: no GI symptoms 1: stomach cramps 2: nausea or loose stool 3: vomiting or diarrhea 5: multiple episodes of diarrhea or vomiting
Sweating: over past 1/2 hour not accounted for by room temperature or patient activity. 0: no report of chills or flushing 1: subjective report of chills or flushing 2: flushed or observable moistness on face 3: beads of sweat on brow or face 4: sweat streaming off face	Tremor: observation of outstretched hands 0: no tremor 1: tremor can be felt, but not observed 2: slight tremor observable 4: gross tremor or muscle twitching
Restlessness: Observation during assessment 0: able to sit still 1: reports difficulty sitting still, but is able to do so 3: frequent shifting or extraneous movements of legs/arms 5: unable to sit still for more than a few seconds	Yawning Observation during assessment 0: no yawning 1: yawning once or twice during assessment 2: yawning three or more times during assessment 4: yawning several times/minute
Pupil size 0: pupils pinned or normal size for room light 1: pupils possibly larger than normal for room light 2: pupils moderately dilated 5: pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0: none 1: patient reports increasing irritability or anxiousness 2: patient obviously irritable or anxious 4: patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches: if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored 0: not present 1: mild diffuse discomfort 2: patient reports severe diffuse aching of joints/muscles 4: patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0: skin is smooth 3: piloerrection of skin can be felt or hairs standing up on arms 5: prominent piloerrection
Runny nose or tearing: Not accounted for by cold -symptoms or allergies 0: not present 1: nasal stuffiness or unusually moist eyes 2: nose running or tearing 4: nose constantly running or tears streaming down cheeks	Total Score:
Mild: 5-12 Moderate: 13-24 Moderately Severe: 25-36 Severe: 36<	

TABLE 4

Dose Adjustment for Renal Impairment		Dose Adjustment for Hepatic Impairment	
Mild to Moderate Impairment: eGFR: 30 – 89.9	2 tablets four times daily (1.44 mg per day)	Mild impairment Child-Pugh Score: 5-6	3 tablets four times daily (2.16 mg per day)
Severe Impairment, ESRD, or on Dialysis: eGFR: < 30	1 tablet four times daily (0.72 mg per day)	Moderate Impairment Child-Pugh Score: 7-9	2 tablets four times daily (1.44 mg per day)
** - eGFR measured in mL/min/1.73 m^2		Severe Impairment: Child-Pugh Score: >9	1 tablet four times daily (0.72 mg per day)

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1. Based on the DSM-5 diagnosis of OUD, a patient presenting with a strong craving for opioids, recurrent opioid use affecting work, using opioids on long drives, a high tolerance threshold for opioids, and taking 10 tablets of Norco 10mg/325 daily would be classified as…?
   a. Mild
   b. Moderate
   c. Severe
   d. None of the Above
2. Which of the following is a sign or symptom of opioid withdrawal?
   a. Mydriasis
   b. Dry Eyes
   c. Yawning
   d. Both a and c
3. Clonidine has an FDA approved indication for opioid withdrawal symptoms?
   a. True
   b. False
4. Lofexidine is a:
   a. Alpha-2 adrenergic agonist
   b. Beta-1 adrenergic blocker
   c. H2 antagonist
   d. Partial Mu receptor agonist
5. Which scale uses both objective and subjective information from a patient to quantify their opioid withdrawal symptoms?
   a. SOWS
   b. COWS
   c. OOWS
   d. TOWS
6. Which Cytochrome P450 enzyme metabolizes the most lofexidine that reaches the liver?
   a. CYP3A4
   b. CYP2C19
   c. CYP1A2
   d. CYP2D6
7. What would be the dose for a patient with a Child-Pugh Score of 5?
   a. 3 tablets QID
   b. 1 tablet BID
   c. 5 tablets QID
   d. 2 tablets QD
8. Which of the following will cause a serum increase of lofexidine?
   a. Tylenol
   b. Grape Fruit Juice
   c. Paxil
   d. High fat and protein meal
9. If a patient has stopped having withdrawal symptoms on day 6 of therapy, what would be the best option for discontinuing lofexidine?
   a. Take the patient off immediately due to the risk of hypotension
   b. Let the patient finish out the 14 days and then stop
   c. Wean patient off 1 tablet every dose over the next day or two
10. The maximum daily dose of lofexidine is:
    a. 4 tablets (0.72 mg)
    b. 6 tablets (1.08 mg)
    c. 10 tablets (1.80 mg)
    d. 16 tablets (2.88 mg)

42,000 people dying yearly due to an opioid[9], we must have effective means of discontinuing opioids in patients safely. There is no clear guideline on the treatment of patients with opioid withdrawal so the use of medications like lofexidine is up to the clinical decision of the health care team based on patient-specific details.

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