Prescribers and Naloxone Pharmacy Claims

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Smart et al. provide an overview of naloxone prescribing patterns across the USA.¹ We agree with their assertion that greater efforts to promote naloxone prescribing among primary care and internal medicine specialties are urgently needed. As the opioid overdose epidemic evolves and pharmacy naloxone dispensing increases,^{2, 3} it is critical that providers possess clinical knowledge about naloxone and relay information about its purpose and administration to patients. We are writing to caution about an avoidable, unintended adverse consequence of naloxone co-prescribing.

In 2018, the Rhode Island Department of Health enacted regulations mandating that providers co-prescribe naloxone for patients who are (1) prescribed at least 50 oral morphine milligram equivalents per day, (2) currently taking both an opioid and a benzodiazepine or have been co-prescribed either in the past 30 days, or (3) with a history of opioid use disorder or overdose.⁴ In February 2019, a patient who had been prescribed oxycodone to manage her chronic pain for over two decades was co-prescribed naloxone with her usual prescription refill. The patient did not recall being given any instructions or being told about the reason for the naloxone co-prescription by her physician or pharmacist. When she got home, she discovered the naloxone with her opioid prescription and called the pharmacy inquiring about this unfamiliar drug. The pharmacist proceeded to describe to her the proper intranasal administration procedure, and the patient self-administered naloxone while on the phone. The patient recounted almost immediately suffering from nasal drainage, whole body discomfort, chills, nausea, and vomiting. As she recalls, it was only after she experienced these acute opioid withdrawal symptoms that the pharmacist informed her to use naloxone only during an overdose. Following this call, the patient took four times her prescribed dose of oxycodone to override the withdrawal.

Naloxone's opioid blocking effects typically last about 45 min. If a patient takes a high dose of opioids during the period between administration and elimination of naloxone—like the patient in the aforementioned case—they may be at risk of overdose after the naloxone wears off.⁵

Naloxone's life-saving effects cannot be understated, and its co-prescription is an integral step in assisting patients with safe opioid consumption.⁵ This case highlights the importance of ensuring patients understand that naloxone is only for use during an acute overdose and that it can precipitate acute withdrawal.

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