

Role of the clinical pharmacy technician in a Veterans Affairs pain management clinic

The scope of practice for clinical pharmacy specialists within the Veterans Health Administration (VHA) includes independent management of medication therapy. The evolving role of the clinical pharmacist influences the role of the pharmacy technician. VHA recognizes the need for clinical pharmacy technicians and provides guidance on potential activities for clinical pharmacy technicians.¹

The VHA Opioid Safety Initiative launched in October 2013 to improve pain management outcomes and address the risks of long-term opioid therapy. In response, our Veterans Integrated Service Network developed a pain clinical dashboard to facilitate the tracking of high-dose long-term opioid therapy, naloxone distribution, informed consent for long-term opioid therapy, prescription drug monitoring program (PDMP) documentation, and urine drug screen (UDS) monitoring. Furthermore, VHA emphasizes an interdisciplinary patient care model for pain management.² At VA Northern California Health Care System, under the supervision of the pain clinical pharmacy specialists, the pain clinical pharmacy technician (PCPT) position was established to support the provision of safe and optimal long-term opioid therapy.

The PCPT accesses the pain clinical dashboard for patients prescribed long-term opioid therapy. Patients with upcoming appointments are identified and those requiring action are alerted to the provider. In addition, results of PDMP queries are documented, allowing the provider to access information ahead of the appointment.

As a delegate under the pain clinical pharmacy specialist, the PCPT makes inquiries in the PDMP system and enters the results in the patient's electronic health record, documenting non-VHA controlled medications for provider review. In addition, the PCPT assists providers with PDMP queries as requested to facilitate timely decisions about initiating opioid therapy. Providers can ensure there are no duplicate controlled medications or potentially dan-

gerous drug–drug interactions. California Senate Bill 482,³ the Centers for Disease Control and Prevention guideline,⁴ and VHA Directive 1306⁵ provide recommendations for the frequency of PDMP database queries. Adherence to PDMP query recommendations will affect workload; thus, assistance from PCPTs could become increasingly important.

The PCPT assists with obtaining a UDS for patients prescribed long-term opioid therapy. A laboratory order is placed by the PCPT for clinician signature, and laboratory reminder letters and telephone calls are directed to patients for completion. Both the ordering individual and the signing clinician receive alerts regarding UDS results. UDS results are screened by the PCPT for illicit drug use and appropriateness based on the current medication regimen. The PCPT also assists with initiating further action, such as a repeat UDS or confirmatory testing.

The PCPT performs chart reviews to examine intervals for refill and renewal requests for medication adherence, historical UDS and PDMP results for possible aberrant behaviors, and unfulfilled clinic appointments or laboratory tests for continuity of care.

When consultations for the pain clinical pharmacy specialist are ordered, the PCPT evaluates information to determine referral eligibility. Patients taking more than 90 morphine milligram equivalents daily are at highest risk for opioid-related harm and are prioritized. Referred patients are then contacted by the PCPT to schedule an appointment with the pain clinical pharmacy specialist.

The PCPT actively participates in teaching pharmacy students who are completing introductory pharmacy practice experiences in population management for patients prescribed long-term opioid therapy. The PCPT conducts in-classroom training at the University of the Pacific on navigating the electronic health record, including the laboratory, pharmacy, and patient demographic sections. In addition, strategies are provided to conduct accurate

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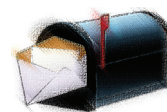
The Letters column includes the following types of contributions: (1) comments, addenda, and minor updates on previously published work, (2) alerts on potential problems in practice, (3) observations or comments on trends in drug use, (4) opinions on apparent trends or controversies in drug therapy or clinical research, (5) opinions on public health issues of interest to pharmacists in health systems, (6) comments on ASHP activities, and (7) human interest items about life as a pharmacist. Reports of adverse drug reactions must present a reasonably clear description of causality.

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PDMP queries. During the introductory pharmacy practice experience, the PCPT is available to students for questions as they arise.

The PCPT communicates directly with patients regarding the need for a UDS or long-term opioid therapy informed consent. In addition, the PCPT provides education regarding the clinic process and specific information about upcoming appointments, such as preparation for the naloxone education appointment. The PCPT is a highly accessible member of the pain management team, promoting timely communication between the patient and health-care providers. Finally, the PCPT is an active member of the VA Northern California Health Care System pain committee and develops and distributes meeting minutes to other committee members.

The ASHP Ambulatory Care Summit recommended optimization of the role of pharmacy technicians in order to improve access to pharmacist-provided patient care.⁶ Appreciation of the expanding role of pharmacy technicians is increasing; the value of pharmacy technicians is recognized in anticoagulation clinics, in emergency departments for medication reconciliation, and within the inpatient pharmacy for “tech-check-tech.”⁷⁻⁹ Our experience with a PCPT highlights the expanding role of pharmacy technicians within pain management and opioid safety.

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Coenzyme Q10 for statin-associated myalgia

We read with great interest the article by Tan and Barry¹ about coenzyme Q10 supplementation in the management of statin-associated myalgia (SAM) and believe that the authors omitted clinically relevant information. We use coenzyme Q10 supplementation in our practice and believe it plays a role in a subset of patients experiencing SAM.

In its pure form, coenzyme Q10, or ubiquinone, is a water-insoluble powder and has incomplete lipid solubility, resulting in poor absorption and limited oral bio-

availability.^{2,3} However, there are pharmacokinetic data demonstrating that the reduced form of coenzyme Q10, or ubiquinol, has greater bioavailability and produces higher plasma concentrations when consumed orally, compared with ubiquinone.^{4,5} Therefore, the ubiquinol formulation may be more likely to provide benefit in certain patients with SAM. Although Tan and Barry briefly discussed coenzyme Q10 product variability, they did not mention ubiquinol specifically or list it among their search terms.