For decades, patients, caregivers, and sometimes even hospice staff, have erroneously believed that morphine use hastens death. However, these same people have continued to use morphine believing that the provision of a pain-free death is more important than extending the dying process. After the death of a loved one who was treated with morphine or other opioids at the end of life, too many caregivers are left with feelings of unrest regarding having allowed the opioids to be used. In order to prevent caregivers from carrying around guilt years after the death of their loved one and to eradicate these long-standing, widespread myths, education regarding the erroneous nature of these ideas should be provided to all hospice staff, patients, and caregivers, regardless of whether they verbalize belief in such myths or not. Several common myths can be easily countered by the facts surrounding morphine and its appropriate use.

Myth: Caregivers are at high risk of expediting death if administering morphine as needed to control the patient’s pain.

Truth: Morphine would have to be administered at doses that would cause bothersome toxic effects such as distressing agitation and myoclonic twitching before causing death. Morphine has a wide therapeutic range, making actual overdose rare. Even when high doses of morphine (greater than 300 mg/day) are necessary for pain control, patient survival is not affected.

Myth: Morphine will make patients comatose.

Truth: Morphine can cause some sedation initially, but this effect decreases within a few days. Due to its actions to decrease pain and ease shortness of breath, hospice staff often observe that morphine enables patients to catch up on sleep that has been lost as a result of these distressing symptoms. Thus, patients will likely sleep more once morphine is initiated but not because the drug is inducing a comatose state.

Myth: Morphine will cause respiratory depression along with pain control, expediting death.

Truth: Studies show that if opioids are titrated against symptoms, they do not hasten death. Also, patients develop a tolerance to the potential respiratory depression effects of morphine at oral doses of 60 mg per day or greater, such that respiratory depression rarely occurs in patients who have been on morphine for more than seven days.

References:
Options for Switching Antipsychotics

Medication cost, adverse effects, and poor therapeutic response often necessitate switching a hospice patient from one antipsychotic to another. Prescribers can choose among several options when a switch is necessary.

**Abrupt switch:**
Often preferred by hospice prescribers, one antipsychotic can be abruptly discontinued with the immediate start of a new antipsychotic at a therapeutic dose.

**Gradual tapering:**
The initial antipsychotic dosage can be decreased by 25 to 50% of the total daily dose every four or five half-lives with concurrent up-titration of the new antipsychotic. Refer to the chart of half-lives of common antipsychotics.

**Overlap:**
When overlapping products, the initial antipsychotic is continued at full dose while titrating the patient’s new antipsychotic. When the new antipsychotic is at a therapeutic dose, the initial antipsychotic is tapered for discontinuation.

Since no one option is universally superior to another, prescribers must select the best switch method on a patient-by-patient basis. Patient prognosis, patient stability, clinical status, efficacy of current medication(s), type of side effect(s) present, potential side effects of the new antipsychotic, and caregiver limitations are important factors that must be considered.

Problems occurring early after a switch can include psychotic symptoms, insomnia, anxiety, agitation, and extrapyramidal effects. Since these effects can be either a response to the new medication or a result of withdrawal of the previous medication, they can be managed in various ways. Watchful waiting is often preferred when symptoms are mild. A slow restart of the initial antipsychotic may be necessary if severe rebound effects or withdrawal symptoms are present. When the switch results in anxiety and restlessness, the addition of a benzodiazepine can provide temporary benefit of withdrawal effects, allowing clinicians to wait to see how the patient tolerates the switch once withdrawal dissipates.

### Half-Lives of Common Antipsychotic Medications

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Half-Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>15-37 Hours</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>21 - 54 Hours</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>6 Hours</td>
</tr>
<tr>
<td>Risperidone</td>
<td>3 Hours in Extensive Metabolizers</td>
</tr>
<tr>
<td></td>
<td>20 Hours in Poor Metabolizers</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>7 Hours</td>
</tr>
</tbody>
</table>

References:
Understanding Common Drug Pricing Terminology

Pharmacies and hospices are challenged in today’s marketplace to fully understand how pricing is in fact determined. In an effort to help hospices decipher and understand their pharmacy agreements, the following definitions could be helpful:

**AWP, n.**
*Average Wholesale Price, n.*
(á/ vèr/ â/ gè —wh/ ò/ le/ sâ/ lè— pr/ì/ cè [noun]
1. intended to represent the average price that pharmacies pay to the wholesalers for their inventory of drugs
2. Does not represent the actual purchase price of generic drugs for pharmacies.
3. Does reflect the actual purchase price of branded drugs.

**Dispensing Fees, n**
(dï/ sp/ êns/ í/ng — t/ éë/ s [noun]
1. a fee charged by a pharmacy for filling a prescription.

**MAC, n.**
*Maximum Allowable Cost, n.*
máx/ í/ mûm — ò/ ë/ w/ å/ biè — C/ ò/ st [noun]
1. the price for generic drugs set by a PBM that is based on what the pharmacy truly paid.

**PBM, n.**
*Pharmacy Benefit Manager, n.*
(phá/ r/ mä/ cÿ —bên/ è/fít— mä/ ná/ gër [noun]
1. referring to a third party administrator of prescription drug programs. They are primarily responsible for processing and paying prescription drug claims.

**PURE Pricing, n**
(p/ û/ ré/ — pr/ i/ cí/ ng [noun]
1. what the pharmacy is paid (their reimbursement) passed directly on to the hospice without the addition of any other fees or profits (spread).

**Reimbursement Rate, n**
(réi/ m/ bûr/ sê/m/ënt — r/ å/ tê [noun]
1. what the pharmacy is paid for a drug from a PBM.

**Spread, n.**
(sp/ r/ éä/ d [noun]
1. the difference between what a pharmacy is reimbursed and what the hospice is charged.

**True Acquisition Costs, n.**
(tr/ ë/ é —ac/qù/ì/ sí/ ìë/ n— C/ ò/ st/s [noun]
1. the actual amount a party pays for a drug.

**WAC, n.**
*Wholesale Acquisition Costs, n.*
(whò/ lë/ sâ/ lê —acqù/ ï/ st/ lôn— c/ ò/s/ ts [noun]
1. the manufacturer’s list price of a drug when sold to the wholesaler
2. More reflective of what the pharmacy actually pays for generics.

The hospice industry is moving away from traditional AWP-based pricing contracts with pharmacies because it allows for too many unknown variables that elevate their drug costs. By demanding transparent pricing that itemizes actual drug costs, administrative fees, processing fees and the like, hospices are better positioned to evaluate what they are paying for different pharmacy services. The result is more competitive hospice-pharmacy contracts which leave more resources available to provide patient care. Origins’ PURE pricing eliminates all spread between the pharmacy and the hospice and offers pricing that meets the needs of both parties. For more information on how your hospice can become an Origins Pharmacy Solutions client and benefit from our PURE pricing model, please contact Jim McClain, Director of Sales, at jmcclain@originspharmacysolutions.com or 208-639-1426.
About Origins Pharmacy Solutions®

Our mission is to simplify the pharmacy benefit process for end-of-life care.

Origins Pharmacy Solutions® partners with hospice organizations and local pharmacies allowing them to provide exceptional patient care while we help control all pharmacy-related costs and administrative burdens. Together, the hospice, pharmacy, and Origins (the pharmacy administrator) form a synergistic team of experts where each team member is able to focus on what they do best.

- The hospice provides superior patient care.
- The dispensing pharmacy ensures effective medications are provided to the patients when and where they are needed.
- Origins provides complete pharmacy program administration which effectively finds the optimal balance between pharmacy profit and hospice expense while relieving both entities of burdensome data management.

Origins’ clients also enjoy access to numerous customizable management reports that can be uploaded directly into your EMR. This includes the CMS required CR 8358. A Geriatric Certified Doctor of Pharmacy performs all Medication Therapy Reviews (MTRs) and Nationally Certified Pharmacy Technicians are available 365/24/7.

Origins Pharmacy Solutions® provides an extensive list of services, including:

- Pharmaceutical Expense Management
- Clinical Consulting Services
- CR8358 Reports formatted to fit your EMR software
- Formulary Guidance
- Real Time Reporting and Online Administration
- PURE Discounted Drug Pricing (no PBM mark-ups)
- Itemized & Competitive Fees for Pharmacy Management
- CoP Compliant Medication Therapy Reviews

We strive to keep our relationships strong with local pharmacies – keeping hospice business in the communities they serve. Origins is contracted with over 60,000 pharmacies nationwide – making it simple and convenient to fill prescriptions at Origins’ discounted pricing.

We offer several pricing and formulary options including our Manual of Appropriate Pharmacotherapies® (MAPs®) which allows hospice to select the most cost-effective, evidence-based, and hospice-related medications. Our goal is to keep our customers’ drug costs low, simplify the pharmacy process for end-of-life care, and provide other much needed pharmacy-related services, all while exceeding our clients’ expectations in customer service. Call today for an individualized proposal that addresses your specific area(s) of need!

Scan this code to visit our website!