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Ask The Pharmacist

To suggest a topic, send an email to: AskThePharmacist@cvty.us.com

Is there a difference between opiates and opioids?

In common use, the terms "opiate" and "opioid" are often used interchangeably. This terminology is imprecise, overlapping, and speaks more to the source and manufacturing method than newer descriptions that more precisely define the biologic activity or relative potency of each opioid substance.[1,2] So, let's define them as they are frequently used and understood.

"Opiate" is a term commonly used to describe naturally occurring substances in opium, a product of nature — a milky, resinous extract harvested from the Asian Poppy (Papaver Somniferum), whose Latin name means "milk, carrying sleep." This poppy plant is native to areas of East Asia and South America and archeological evidence of its use dates back to 3500 BC.[3] In history, the course of human civilizations have been significantly changed, wars have been fought, and ritual significance has been attributed to the use of opiates.[4] Their benefit in relieving pain comes with a serious caution related to their inducing physiologic tolerance, euphoria, craving, and addictive properties. The medical history of opium dates to some of the oldest known descriptive texts, with early note of its use to promote sleep and relieve pain.[5] Patent medicines, popular in western civilization and the early U.S., were often tinctures (alcoholic extracts) of opium.

Of 20 or so substances naturally present in opium, morphine, codeine, and thebaine are the best recognized from a group called phenanthrenes that are psychoactive (having a significant effect on mental processes). Another group called isoquinolones are not psychoactive but have antispasmodic (calm muscle spasms) and vasodilatory (dilate blood vessels) properties that make them medically useful. Papaverine is an example of these, widely available in the U.S. and indicated for several conditions characterized by smooth muscle spasms (e.g., acute myocardial infarction, angina, peripheral vascular disease).[6]

"Opioids" are, as the word suffix suggests, "similar to" opiates. Semisynthetic opioids are first cousins of opiates, altered slightly from their natural structure to promote potency or duration of activity. Hydrocodone, hydromorphone, and oxycodone are examples of semisynthetic opioids, derived from morphine and prescribed for moderate to severe pain. Buprenorphine, a semisynthetic opioid, is derived from thebaine and has receptor activity that differs from morphine derivatives, making it useful in medication assisted treatment (MAT) for addiction. Heroin is a semisynthetic opioid, derived from morphine, which holds no described medical use in the U.S., but is widely misused and trafficked in illicit channels.

Synthetic opioids, like tramadol, fentanyl, tapentadol, and methadone, are produced in laboratories to closely resemble the activity of opiates but modify their potency and/or receptor affinity to obtain specific medical advantages. Fentanyl, for example, is 50-80 times more potent than morphine, and was developed to provide improved analgesia for patients with hard to treat cancer pain, but has also been produced in illicit labs and become a major adulterant in other substances of abuse, making it responsible for a great number of overdose deaths.[7] Tramadol and tapentadol, also synthetic opioids, are designed to deliver the analgesic advantages of an opioid, while mitigating the craving and addiction potential.

To summarize, opiates are naturally occurring substances present in opium. Semisynthetic opioids are slightly modified versions of opiates and synthetic opioids are products of medicinal chemistry, produced in laboratories. All of these share properties and cautions in common with opiates and should be prescribed judiciously at the lowest effective dose for the shortest amount of time necessary to avoid the predictable side effects, medical, legal, economic, and social consequences of their use.

1. http://info.iwpharmacy.com/opiate-opioid-narcotic-whats-the-difference
2. https://www.acsh.org/news/2017/10/27/acsh-explains-whats-difference-between-opioids-and-opiates-12041
3. https://www.deamuseum.org/ccp/opium/history.html
4. https://www.history.com/topics/crime/history-of-heroin-morphine-and-opiates
5. https://www.ncbi.nlm.nih.gov/pubmed/17152761
6. https://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1953-01-01_3_page005.html
7. http://www.drugpolicy.org/what-are-synthetic-opioids-fentanyl

Drug of the Month

Suboxone® (buprenorphine and naloxone)

Suboxone (buprenorphine and naloxone) is one of several medications approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid dependency.[1] It is available in several dosage formulations, including sublingual tablets and buccal films (tissues which line the oral cavity), and is one of several medication options used for this purpose. It should be said that any medication treatment for opioid dependency is most effective in combination with behavioral therapy, otherwise known as medication assisted treatment, or MAT.[2]

Suboxone is a combination product containing buprenorphine, a synthetic opioid that functions as a partial opioid agonist, and naloxone. By comparison to full opioid agonist medications (like morphine, oxycodone, or methadone), it also enables relief of pain, but has reduced potential for respiratory depression, reduced stimulation of "pleasure centers" in the brain that promote craving, and limits withdrawal symptoms as the dose is reduced over time.[3] These differences, which make Suboxone useful in taper strategies for opioid weaning, don't alter the essential identity of buprenorphine alone, as an opioid, with the potential to induce physiologic tolerance, craving and addiction, or to be fatal in overdose.

Suboxone also contains naloxone, which adds an abuse-deterrent feature to the product. Naloxone is an opioid antagonist that reverses the activity of opioids when it reaches the brain in sufficient concentrations. It is not well absorbed in the gut and exerts little or no effect by the oral route, allowing the buprenorphine component to relieve pain. If it's altered for illicit use by nasal snorting or IV injection, the antagonist portion of the pill (naloxone) will reduce or counteract the opioid-induced euphoria.[2]

A significant advantage that Suboxone offers in clinical practice is that its abuse deterrent properties make it more available to offer in office treatment settings, as opposed to a smaller number of federally regulated clinics for methadone, where closer medical supervision is required. Through this advantage, access to MAT is greatly expanded at a time when its badly needed.[2]

1. https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022410s000lbl.pdf
2. https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5855417/

First Script® Annual Drug Trends Series

Part Three: Evaluating Opioid Trends

In part three of our series we look at opioids, which continue to decrease in proportion to overall scripts and costs, with favorable trends in MED, duration of use, and access to guideline-supported measures including MAT and overdose rescue medications. See the infographic.

Clinical Updates

New York Formulary and Prior Authorization Portal

The NYWCB plans to make available an electronic drug formulary prior authorization portal in November 2019. To find out more about the portal and additional formulary changes read our First Script bulletin.

RELPAX® 40mg Tablets Recall

Pfizer has issued a voluntary recall for two lots of RELPAX® 40mg tablets due to potential contamination. RELPAX is indicated for the treatment of migraines. For additional recall information, read our First Script bulletin.

Governmental Activity by State

Find out more about the governmental updates and potential changes currently being proposed in your state

To find out more about the governmental updates and potential changes currently being proposed in your state, visit the Coventry News and Insights Page each month to read our Government Relations Newsletter. Find this month's newsletter here.

Texas

Texas HB 2174 established opioid prescribing limitations for the treatment of acute pain. The bill states that effective September 1, 2019, a practitioner may not issue a prescription (initial or refill) for an opioid in an amount that exceeds a 10-day supply. Exceptions include: chronic pain, pain as part of cancer care, pain as part of hospice or other end-of-life care, and pain as part of palliative care. Additionally, the limitation does not apply to any prescriptions for opioids approved by the FDA that are issued by a practitioner for the treatment of substance addiction. Effective September 1, 2019, First Script limited all opioid scripts to a 10-day supply if there is no history of opioid scripts in the previous 90 days. Smart Authorization Management has also been configured to address this limitation and provides appropriate state-specific messaging to help guide authorization on the impacted claims.