As a result of known situations where a single insulin pen was used for multiple patients, the Food and Drug Administration required pen manufacturers to include a statement, “For single patient use only,” on all pens and outer cartons. The statement seems cut and dried. However, a patient who was newly started on NovoLOG Mix 70/30 (insulin aspart protamine and insulin aspart) thought “single patient use” meant to administer the entire contents at once. The patient had not received any education about administration technique or dosing. It is unknown if the patient received 60 units (the maximum that can be dialed as a single dose) or the entire 300 units in the pen. The patient became unresponsive and was brought to the hospital with a blood glucose level below 30 mg/dL. The patient was placed on a 10 percent dextrose infusion and became responsive. When educating patients about the use of insulin pens, be sure to discuss the meaning of “For single patient use only.”

POTENTIAL NAME CONFUSION BETWEEN HIGH-ALERT MEDICATIONS
A prescriber transmitted an electronic prescription for the direct oral anticoagulant apixaban (Eliquis) 5 mg twice a day to a pharmacy. When entering the prescription, the pharmacist could not identify in the patient’s profile a reason why the patient needed to take an anticoagulant. The pharmacist contacted the prescriber to discuss the prescription and verify it was for the correct drug. The prescriber had meant to prescribe axitinib (Inlyta), an oral antineoplastic agent used to treat advanced renal cell carcinoma after failure of one prior systemic therapy. Both apixaban and axitinib can be dosed at 5 mg twice a day. While this error was intercepted before reaching the patient, the pharmacy thought it was important to share so others can be on the lookout for similar mix-ups. Reviewing the patient’s profile when dispensing prescriptions can intercept errors as it did in this case. Prescribers can improve care coordination and patient safety by including the purpose of the medication on the prescription.

FOUR-LETTER SUFFIXES WITH NEW BIOLOGICS
Why are we seeing four-letter suffixes with newly approved biological medications (such as filgrastim-aafi, infliximab-dyyb)? A guidance, called Nonproprietary Naming of Biological Products (https://bit.ly/2Ja7MV4) issued by the FDA in January 2017, clarified the need for identifying specific biological products with these suffixes to facilitate pharmacovigilance and safe use. The nonproprietary name for newly approved biological products is now a combination of the core name and a distinguishing suffix attached with a hyphen. This suffix is devoid of any specific meaning, is composed of four lowercase letters, and applies to the entire drug name.

Unlike generic drugs, with biologicals, it is not possible to develop exact copies of the same molecule. Therefore, manufacturers may use slightly variant living organisms or processes to create products referred to as “biosimilars.” The four-letter suffix naming convention will help differentiate versions of the same biological medication and ensure the safety of patients by identifying the specific product that may be associated with an adverse event.

When a biological nonproprietary drug name is used, it is highly recommended to express the full name, including the suffix, whether the biological is being added to an electronic health record or identified in an adverse event report. ISMP also encourages using the brand and nonproprietary names together to provide redundancy and avoid name confusion.

This article is from the Institute for Safe Medication Practices. The reports described were received through the USP–ISMP Medication Errors Reporting Program. Errors, near-misses, or hazardous conditions may be reported at www.ismp.org. ISMP can be reached at 215-947-7797, or ismpinfo@ismp.org.