

Drug Names That Are Too Close for Comfort

Look- and sound-alike similarity between the official names clobazam **(ONFI)** and clonaze**PAM (KLONOPIN)** has led to several reports expressing concern that patients may inadvertently receive the wrong medication in either hospital or outpatient settings. The drugs share similar indications, although they have 10-fold strength difference in available dosage forms. Clobazam was approved by Food and Drug Administration in October 2011 for adjunctive treatment of Lennox-Gaustaut seizures and other epileptic syndromes. Lennox-Gaustaut is a form of childhood-onset epilepsy characterized by frequent seizures and different seizure types, often accompanied by developmental delay and psychological and behavioral problems.

Clobazam is available in 5 mg, 10 mg, and 20 mg tablets. Clonaze**PAM** also is approved for seizure disorders (including Lennox-Gaustaut) and panic disorders and is used off-label in a variety of conditions. Clonaze**PAM** is available in 0.5 mg, 1 mg, and 2 mg tablets and oral disintegrating tablets of similar strengths (0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg). The potential for error with clobazam and clonaze**PAM** seems obvious. In one case this was discovered when a pharmacy department was discussing the potential addition of clobazam to the hospital formulary. In another, a pediatric intensive care unit nurse asked for clonaze**PAM** after receiving an order for clobazam. A pharmacist followed up and the error was identified. We will be adding clobazam to our *List of Look-Alike Drug Names with Recommended Tall Man Letters* in an upcoming revision. Preliminarily, we have identified that clo**BAZ**am may be the best option to differentiate it from clonaze**PAM**, which is already on the list for potential confusion with clo**NID**ine, clo**ZAP**ine and **LOR**azepam. Since clonaze**PAM** has been on the market for so long, practitioners are much more familiar with clonaze**PAM** and therefore at risk of "seeing" prescriptions for the newer product clobazam as the more familiar clonaze**PAM**.

USE TWO IDENTIFIERS AT THE POS

Within the span of a couple of days, the Institute for Safe Medication Practices received two more reports of wrong patient errors at the point-of-sale. Both were submitted by the parents of the patients involved. In one event, a teenager, who was supposed to receive methylphenidate for Attention Deficit Hyperactivity Disorder (ADHD), was given a cardiac drug intended for a different patient. The mother who was picking up the prescription for her son caught the error because the pharmacist mentioned that "this will help with the chest pains." Of course, this means that the other patient was given the methylphenidate instead of the cardiac drug. It turned out that the teenager and the other patient had the same name.

In the second case, a patient was dispensed am**LODIP**ine, a calcium channel blocker, instead of the anticonvulsant gabapentin. The am**LODIP**ine was intended for a different patient. Both patients shared the same first name and the same first three letters of last name. To help reduce the risk of these errors, standardize and monitor the systems and processes in place at the point-of-sale. Require pharmacy personnel to ask the person picking up the completed prescription to supply the patient's name as well as the patient's date of birth. Also, personnel should open the bag with the patient at the POS and have the patient look at the prescription vials and the medications they contain to verify what was ordered and expected. Pharmacy managers and/or regional personnel for chain pharmacies should periodically perform quality control checks by observing the processes at the POS to ensure adherence to the standardized work practices. ■

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