Pharmacist's Letter
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Minimize Mix-Ups With Pen Injectors

You play a big role in **preventing errors with pen injectors**.

Stay sharp for product mix-ups. For example, tirzepatide (*Mounjaro*) can easily be mistaken for the osteoporosis med teriparatide (*Forteo*)...and they're both prefilled pens that are kept in the fridge.

Plus a med can be available in more than 1 type of pen. For instance, insulin glargine U-100 (*Basaglar*), lispro (*Humalog*), and lispro-aabc (*Lyumjev*) come as a *KwikPen* AND a *Tempo Pen*. *Tempo Pen* works with a "smart button" to send info about doses to a mobile app.

Reinforce with your team to read through product names completely when entering Rxs...pulling products from the fridge...stocking...etc.

For similar-looking pens...or for different strengths of the same med...ensure safeguards are in place, such as storing in separate locations or using shelf tags.

Limit problems with pen needles. For instance, needles are included with *Ozempic*...but not with *Humalog KwikPen* or *Victoza*. And not dispensing an appropriate pen needle with these products can lead to missed doses, reusing needles, etc.

When dispensing a pen, check labeling to see if it comes with needles...or if there's a pen-needle Rx that also needs to be filled.

Watch for late refills on pen needles. This could be a sign that patients are reusing them for multiple injections...which may lead to contamination, injection pain, and wrong doses.

Promote proper use. For example, most insulin pens (insulin aspart, etc) should be primed before EACH injection...and many GLP-1 agonists (*Byetta*, *Victoza*, etc) should be primed only before the FIRST use.

But dulaglutide (*Trulicity*) should NEVER be primed. Be sure to counsel patients and caregivers on priming, dialing, giving a dose, etc...to help avoid errors.

In one case, a caregiver saw "single patient use" on an insulin pen...and administered the entire pen as a single dose. The patient ended up in the hospital needing a glucose infusion.

For more strategies to prevent errors with insulin products, see our resource, Tips to Improve Insulin Safety.

Key References:

-FDA. How to Avoid Medication Errors with Pen Injectors. March 13, 2024. https://www.fda.gov/about-fda/fda-pharmacy-student-experiential-program/how-avoid-medication-errors-pen-injectors (Accessed July 10, 2024).
-ISMP. Medication Safety Alert! October 2021. https://www.ismp.org/communityambulatory/medication-safety-alert-october-2021 (Accessed October 19, 2023).

Pharmacist's Letter. August 2024, No. 400803