Opioid Prescribing Guidelines

Due to the high level of prescription drug use and abuse in Lake County, these guidelines have been developed to standardize prescribing habits and limit risk of unintended harm when prescribing opioid analgesics.

These guidelines acknowledge that every patient has a right to be assessed for pain and if the patient is found to have pain, have a plan of care developed to manage pain. The intention of these guidelines is to ensure that providers assess all options for treating pain, and decide on the safest, most appropriate pain management method. These guidelines do not apply for treatment of cancer or palliative care patients.

Safe Opioid Prescribing Guidelines for ACUTE Non-Malignant Pain

☐ Long-term opioid use often begins with treatment of acute pain. Reflexive use of low potency opioids such as codeine and hydrocodone in context of acute self-limited pain has contributed to the growing problem of opioid abuse and dependency. Opioid medication should be avoided in the management of acute pain, when it is clinically reasonable and appropriate to do so.

☐ In studies of patients undergoing low risk outpatient surgery (such as cataract, vein stripping) who were given opioids within the first 7 days of surgery, 7% remained on opioids at 1 year. Patients given opioids in the first 15 days of occurrence of acute low back pain were two times more likely to be given five prescriptions of opioids over the next 30-730 days. (*Ref http://archinte.jamanetwork.com/article.aspx?articleid=1108765*)

Considerations

- Are there alternatives to opioid therapy that may provide adequate relief? Often times rest, education, heat or cold therapy, acetaminophen, and NSAIDS may be sufficient for treating pain. Consider these alternatives prior to opioid initiation.
- Is this patient at risk for long term opioid use? Prior to starting opioids, screen patients to assess the risk for opioids-related harms.
- When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.

Safe Opioid Prescribing Guidelines for CHRONIC Non-Malignant Pain

Questions to Consider Prior to Opioid Initiation:

☐ Are you treating the **right patient**,
for the **right reason**,
at the **right dose**
and for the **right duration**?

Considerations

- When evaluating whether or not to prescribe opioids, it is important to know the facts. Research has shown that opioids show no benefit with chronic low back pain, migraines, or fibromyalgia. It is seldom appropriate to prescribe opiates at the first visit, and opioid use for more than 90 days significantly increases the likelihood of lifetime use. The risks vs. benefits of opioid use should be strongly considered prior to initiation.

Determining When to Initiate or Continue Opioids for Chronic Pain

☐ 1. **Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.** Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

- First Consider: exercise, physical therapy, Cognitive Behavioral Therapy, Mindfullness Training, Other Behavioral Therapies, Surgeries/Other Procedures
- Opioid selection, initial dosing, and dose adjustments should be individualized according to the patient's health status and history
- See Appendix 1 for high-risk patient groups

☐ 2. **Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients**, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Patients need to be actively involved in creating a treatment plan. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

☐ 3. Before starting and periodically during opioid therapy, clinicians should **discuss with patients known risks and realistic benefits of opioid therapy** and patient and clinician responsibilities for managing therapy.

Patients should be aware that:

- Opioids are the leading cause of drug overdose deaths nationally
- Opioids can cause harm (such as hypogonadism, adrenal insufficiency, ileus) or death if not managed safely
- Taking opioids puts them at risk of cognitive impairment that can adversely affect the patient's ability to drive, work in a safety-sensitive position, or safely do other activities

Questions to Consider Prior to Opioid Initiation:

Right Patient for Treatment:

Have old records been reviewed?

- Has a CURES report been reviewed?
- Has the patient failed a non-opioid trial?
- Has the patient been given informed consent, reviewed risks and benefits or entered into a pain agreement?
- Does the patient have risk factors for medication abuse/misuse?
- Does the patient have reasonable treatment goals?

Right Reason for Treatment:

- What are the symptoms?
- What is the diagnosis?
- Are the physical findings consistent with the symptoms and diagnosis?
- Is there clinical evidence that opioid treatment is effective for this diagnosis?

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

☐ 4. **When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/ long-acting (ER/LA) opioids.**

☐ 5. **When opioids are started, clinicians should prescribe the lowest effective dosage.** Use caution when prescribing opioids at any dosage, carefully reassess evidence of individual benefits and risks when increasing dosage to 50 morphine equivalent dose (MED) or more per day, and avoid increasing dosage to 90 MED or more per day or carefully justify a decision to titrate dosage to 90 MED or more per day. All new opioid prescriptions should be considered "trials" that the patient understands may be halted should side effects, addictive behaviors, or treatment failure become clinically relevant. Enhancement of the patient's functional status is the clinical goal of new opioid therapy. For patients on an opioids with a MED > 50 MED, consider prescribing naloxone.

Assessing Risk and Addressing Harms of Opioid Use

☐ 7. **Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.** Incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use are present.

- Consider restricting patient access to one provider and one pharmacy
- Ensure patient understands proper and secure storage of medication
- Ensure patient understands proper disposal of unused medication

Monitoring should include documentation of response to therapy, adverse events and adherence to prescribed therapies.

Questions to Consider Prior to Opioid Initiation (Cont.):

Right Dose of Treatment:

Have you considered the risk? Mortality risk increases with:

- morphine equivalent doses (MED) over 90 MED
- opioids with benzodiazepines
- more than 40mg of methadone a day
- history of substance misuse or illicit drug use

Right Duration of Treatment:

- Do you reassess treatment at every visit?
- Do you look for improved function as much as level of pain control?
- Do you perform random drug screens?
- Do you run CURES at least once a year?

Assessing Risk and Addressing Harms of Opioid Use (Cont.)

☐ 8. **Clinicians should review the patient's history of controlled substance prescriptions using CURES data** to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Review CURES data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

In addition to CURES, also review the following:

- Current medications (opioid and non-opioid)
- Prior pain treatment and results
- Relevant and specific physical examination
- Mental health history
- Including a functional description of limitations on the patient's activities due to pain

Using a validated screening tool to determine the patient's risk for harmful drug related behavior

☐ 9. **When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually** to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

☐ 10. **Clinicians should recognize that high-risk patients, including those with significant psychiatric co-morbidities, may require specialty care.** Treatment of some co-morbid conditions may be less effective when opioids are used. Chronic opioid therapy may not be safe or effective absent needed specialty care.

☐ **11**. **All inappropriate or red flag behaviors should be well documented in the medical record and all appropriate personnel should be notified.** These behaviors warrant increased scrutiny of patient medication use, increased frequency of medical and behavioral health visits, smaller/ shorter supplies of pain medications, and as appropriate, tapering or cessation of opioid prescriptions. Referral to available addiction treatment should be considered for red flag behaviors. If the patient has repeatedly confirmed negative urine toxicology for prescribed opioids then a "taper" of prescribed opioids is not indicated; medication prescribing can and should be stopped in the context of frank opioid diversion.

☐ 12. **Clinicians should avoid prescribing opioid pain medication and benzodiazepines, antihistamines, and other sedating medications concurrently whenever possible. To address the side-effects of opioid medication, dose reduction and alternative treatment should be the first strategy rather than additional prescriptions.**

☐ 13. **Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.** SAMHSA defines the symptoms of opioid use disorders to include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

☐ 14. **Birth control should be advised for women of child-bearing age** prescribed chronic opioids to prevent unwanted pregnancy and reduce the possibility of undesired neonatal withdrawal syndrome.

☐ 15. **There should be the co-prescription of naloxone** to individuals a risk for overdose either by the dosage being prescribed (such as MED > 90) or other factors putting the patient at risk for overdose.

Appendix 1

High-Risk Patient Groups

- Caution should be used when prescribing opioid for patients taking other centrally acting sedatives.
- Caution should be used with the administration of methadone. Providers should be aware of the special pharmacokinetics of methadone and the need for careful dosing and monitoring.
- Caution should be used with the administration of chronic opioids in women of childbearing age, as opioid therapy during pregnancy increases risk of harm to the newborn. Opioids should be administered with caution in breastfeeding women, as some opioids may be transferred to the baby in breast milk.
- When chronic opioid therapy is used for an elderly patient, clinicians should consider starting at a lower dose, using a longer dosing interval and monitoring more frequently.
- Caution should be used with patients under age 40 due to increased lifetime exposure to long-term opioid therapy, the risks of central nervous system damage, and the higher rates of misuse among this age group.
- Patients with obstructive sleep apnea (OSA) are at increased risk for harm and death with the use of chronic opioid therapy.
- Caution should be used for patients over age 65 due to declining renal and hepatic function, leading to reduced metabolism and excretion, balance and gait problems, fall risk, declining bone density and muscle mass, and cognitive decline.
- Patients with coexisting psychiatric disorder(s) may be at risk of harm related to chronic opioid therapy. If chronic opioids are used, clinicians should consider careful dose selection, frequent monitoring and consultation where feasible.

Appendix 2

*For additional calculations, please see the GlobalRPh Advanced Opioid Converter (http://www.globalrph.com/opioidconverter2.htm)

Drugs	Approved Dosage Forms and Strengths	Recommended Starting Dose	Frequency (Hours)	Duration of Effect (Hours)	Dose Equivalent to PO Morphine Sulfate 30MG	Dose Equivalent to PO Morphine Sulfate 90MG
Codeine PO	15, 30, 60 mg tablets	15-60mg	4	3-4	333mg	600mg
Fentanyl (transdermal)	12, 25, 50, 75, and 100mcg/hr patch system	NOT for use in opioid naive patients	72	--------	12mcg/hr	37.5 mcg/hr
Hydrocodone bitartrate/ acetaminophen (e.g. Vicodin)	2.5/325-500, 5/300-650, 7.5/300-750, 10/300-750mg tablets	5-10mg/300-750 mg	4-6	4-8	30mg	90mg
Hydromorphone HCl (e.g. Dilaudid)	2, 4, and 8mg tablets	2-4mg	4-6	4-6	7.5mg	22.5mg
Methadone**	**Complex conversions to/from. See http://www.globalrph.com/opioidconverter2.htm					
Oxycodone HCl (e.g. Roxicodone)	5, 10, 15, 20, and 30 mg tablets	5-15mg	4-6	4-6	20mg	60mg
Oxymorphone HCl (e.g. Opana)	5 and 10 mg tablets	5mg	4-6	5-8	10mg	30mg