IMA Safe Opioid Prescribing Guidelines

Last update: December 2017

A. Before Starting Opioids

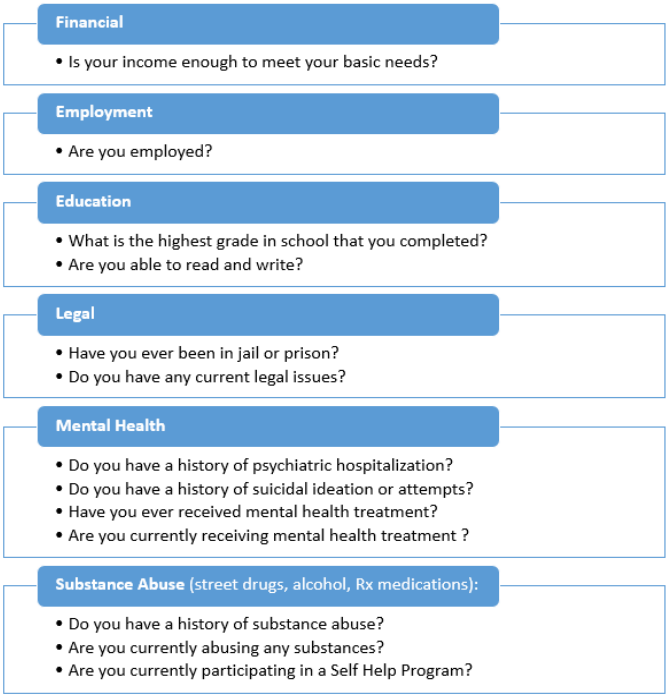
1. Review and try non-opioid medications and complementary therapies before starting opioids.
    a. Review algorithm
2. Assess the benefits versus harms:
    a. Potential Benefits: Analgesia and functional status improvement through SMART goals (specific, measurable, action-oriented, realistic, time sensitive)
        i. **PEG Tool** (assessing analgesia and function)
    b. Potential Risks: Adverse effects, aberrant behavior
        i. Consider prior or active h/o substance use disorder, unstable psychosocial issues, concomitant benzo/alcohol use
        ii. Remember to check iSTOP to make sure patient not getting benzos/opiates from elsewhere

B. Starting Opioids

1. How to discuss starting:
    a. Come to agreement on what problem is being treated
    b. Identify SMART (specific, measurable, action-oriented, realistic, time sensitive) patient treatment goals
        i. Examples of treatment goals:
            1. Using this medication will help me get out of the house with my wife twice per week
    c. Present opioids (and any other treatment for pain) as a test - if goals not achieved, they will stopped and another therapy will be tried
    d. Review the risks (sedation, addiction, constipation)
    e. Discuss that both patient and provider will sign a treatment agreement (Provider Patient Agreement)
    f. Review monitoring practices (scheduled and unscheduled UDT, prescription refill policy)
    g. Set up visit in 2-4 weeks to assess effect of pain medication
2. Creating a treatment plan:
    a. Review opioid therapy as part of larger treatment plan encompassing other non-pharmacologic interventions (exercise, stress management, PT, CBT)
    b. Review expectations (regular appts, pill counts, UDT, only one primary provider/team and pharmacy)

c. Consider the below areas in your understanding of the patient:

i.



d. Choosing an opioid:
   i. **Principle: Start low and go slow**
   ii. Consider prior exposure to opioids
   iii. Short acting opioids: indications (opioid naive, intermittent severe pain, breakthrough) and options (including brand pricing)
   iv. Long-acting opioids: indications (opioid tolerant, constant pain)
   v. Other considerations and testing for certain meds (i.e. QTc, creatinine, liver disease, seizures)
   vi. **See chart** here for different opiate profiles and how to prescribe
   vii. **Try to avoid prescribing more than 50 MME of opioid medications in total** (MME calculator)

3. Monitoring risk:
   a. Tools: UDT (frequency: q6mo for low risk, more often for higher risk, every visit for very high risk)
   b. PDMP (iSTOP) every prescription
   c. Pill counts (strongly recommended at each visit)
4. Prescribing naloxone:
   a. Indications: high dose opioid >50MME, bupe/methadone, h/o SUD/misuse, any opioid rx if also -- recent switch from another opioid, smoking/copd/asthma/OSA/respiratory disesase, renal dysfunction, liver disease, cardiac illness, HIV/AIDS, concomitant EtOH/benzo/sedative/antidepressant; voluntary request
   b. Free naloxone kits can also be provided to patients by the firm RN. Patients will need to stay for 5-15 minute training by the RN on how to use naloxone kit.

5. Talking about overdose:
    a. Talking points for providers
        i. Discuss risk factors for an overdose (changing tolerance, rapid dose escalation, mixing drugs/alcohol)
            1. Discuss increased risk in NYC especially due to fentanyl (being sold and packaged as heroin, cocaine, oxycodone, benzos on the street)
        ii. Discuss signs of an overdose: slow or no breathing, not responding, turning blue
        iii. Naloxone (Narcan) can reverse overdose and save lives; it is free and legal to carry
            1. Only reverses overdose from opiates. However, it is safe to use if not sure what overdose is from.
            2. Non addictive; will cause person to go into withdrawal
            3. Takes 2-3 minutes to work, wears off in 30-90 minutes
        iv. Always call 911 if you think someone is overdosing; you are offered some legal protections for calling
            1. Good Samaritan Law

C. Continuing Opioids

1. Follow-up visits:
    a. Assess benefits, obtain and compare PEG score to prior visit
    b. Determine how patient using opioid
    c. Review side effects
    d. Review other active social, psychiatric issues
    e. Gather objective info: signs of intoxication, withdrawal; check PDMP; review and check UDT
    f. How to communicate next steps: Please see helpful chart with talking points here to discuss the below:
        i. If goals achieved and minimal SE
        ii. If goals achieved and significant SE
        iii. Goals not achieved and minimal SE
        iv. Goals not achieved and significant SE
2. Opioid rotation:
    a. Conversion tool (globalrph.com)
    b. Incomplete tolerance (decrease opioid dose by 25-50% if switching from one opioid to another)
    c. Methadone conversions are challenging - consider consulting IMA opiate committee or pain management
3. Pill counts:
    a. Can be done scheduled or non-rescheduled; Please see here about how to perform.

4. Urine drug testing (UDT)
    a. Screening immunoassays should be ordered routinely at each visit you give a prescription, for most patients (unless low risk)
    b. Confirmatory testing should be ordered when you want to confirm the patient is taking an opiate (when you suspect diversion, concerned patient not taking correctly or about polysubstance use)
    c. How to interpret: Please see this chart about how to interpret findings.

D. Stopping Opioids

1. Indications for stopping:
    a. Definitive indications:
        i. No benefit identified (patient does not have to have diversion or addiction in order to stop opioid therapy)
        ii. Evidence of illegal activity or diversion of medication
        iii. Patient exhibits harms from treatment (overdose, over-sedation, constipation requiring hospitalization)
        iv. Patient cannot keep medications safe (recurrent stolen medication from family member, lost medication)
        v. Patient with evidence of substance use disorder
        vi. Violent or abusive behaviors toward practice staff or clinicians
        vii. Patient unable or unwilling to comply with monitoring requirements
    b. Strong indications:
        i. When the risks of opioid treatment outweighs the potential benefits
        ii. Patient with evidence of using illicit substances (i.e. cocaine), non-prescribed medications (i.e. benzodiazepines) or other risky use of substances (i.e. alcohol)
2. How to stop:
    a. Assess degree of physical dependence: to taper a patient or not
        i. Patients only taking short acting opioids (4 pills a day, any strength) should be able to stop without a taper
        ii. Patients on long acting medication may need taper
        iii. Patients on >50mg MME daily may require a taper, with higher doses more likely (MME calculator)
    b. How to taper (including how to use IR during that time)
        i. Make decision on individual basis after discussion with patient
        ii. Write clear instuctions
        iii. Rx meds for withdrawal symptoms (clonidine, NSAIDs, loperamide)
        iv. Specific suggested tapers for different drugs
        v. Taper 10-20% per week
        vi. Most people can be tapered rapidly in the first 50% of their opioid dose. The last 25% is difficult.
        vii. When tapering off ER/long acting opioids, a short acting (IR) opioid can help with breakthrough symptoms

viii. While tapering ER/LA opioids, build up non-pharmaceutical pain management techniques and non-opioid use
ix. Higher dose short acting agents should not be changed into long acting for the taper as they may increase dependence potential

c. When NOT to taper (i.e. diversion, negative UDT)
i. Evidence of illegal diversion or tampering
ii. Patient with suspected substance use disorder not willing to engage in treatment
iii. Patients without evidence of taking medication (e.g. multiple, negative urine drug screens despite high dose or long acting medication).
iv. Patients on low dose short acting medications
v. Patients with active substance use disorder
vi. If patients are willing to engage in addiction treatment, a short tapering dose is potentially useful to bridge the patient to a detoxification program, or medication assisted treatment (methadone, buprenorphine).

d. Adjunctive treatments
i. Non-opioids (NSAIDs, tylenol, topicals)
ii. Behavioral treatment

3. How to discuss stopping with patients:
a. Discuss clinical rationale (examples below)
b. To learn more about how to respond to the below patient statements, we highly recommend watching the Case Study videos on the SCOPE of Pain website (you need to login/register -> Resources -> Videos)