PARTNERSHIP HEALTHPLAN RECOMMENDATIONS
For Safe Use of Opioid Medications

Primary Care & Specialist Prescribing Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 14 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have launched a community-wide initiative to promote safer use of opioid medications.

Why is this important? In the last decade, the death rate from opioid overdose has quadrupled, making opioid overdose as common a cause of death as motor vehicle accidents. For every overdose death, there are 130 people who have a long-term dependence on opioids and 825 non-medical users of opioids (see figure at end of this policy). These numbers originate in prescriptions for opioid pain medications, written by health professionals, so health professionals must work together to reverse this trend.

Based on his/her skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of pain. In starting analgesics for new onset acute pain, the possibility the acute process will evolve into a chronic pain syndrome should be kept in mind. Chronic pain is defined as pain lasting longer than normally expected for the healing of an acute injury or tissue inflammation, usually in the range of 3-6 months. In this guideline, we are not addressing chronic pain associated with cancer or a terminal disease, conditions in which treatment goals and needs are different than in chronic non-cancer pain.

Use of opioid pain medications for chronic non-cancer and non-terminal pain should be weighed carefully by any prescriber. Chronic use of opioids is associated with an increased risk of addiction, habituation, and tolerance. When combined with alcohol use or with other sedating medications such as benzodiazepines and muscle relaxants, opioid use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid-induced hyperalgesia, which ultimately generates increased pain and debility. Unlike acute pain or pain related to metastatic cancer or end-of-life care, the goal of opioid therapy in chronic non-cancer, non-terminal pain is *improved functioning*, not necessarily *elimination of pain*.

The following standards for opioid use in patients with chronic non-terminal, non-cancer pain are suggested as a starting point from which each community in our PHC region can develop their own standards, for the good of our members and the community.

Recommendations

A. Acute pain. The main goal is to treat pain without creating opioid dependency, tolerance, or hyperalgesia.
   1. Preferentially use non-narcotics as first line therapy, especially acetaminophen or NSAIDS. Remember to be cautious with NSAIDs in seniors and persons with hypertension and azotemia.
   2. Restrict use of narcotic pain medications to situations with more severe pain, e.g. traumatic injuries, and if prescribed, limit their use to short periods.
   3. Discuss the risk of opioid dependence, tolerance, and hyperalgesia with patients being initiated on opioid treatment.

4. Before initiating opioid therapy for acute pain, assess for risk of opioid abuse/diversion using a standardized tool (see appendix for an example). If patient is at high risk, consider a baseline urine toxicology screen and focus on the use of non-opioid modalities to treat pain. Patients between 18 and 25 years of age are at increased risk of abusing prescription drugs, so patients in this age range should be screened carefully.

B. Chronic pain in patients with a remote history of malignancy, but currently in remission, should be treated the same as those with chronic non-cancer pain (see next section).

C. Chronic non-cancer, non-terminal pain

1. Chronic non-cancer, non-terminal pain not responding to non-opioid treatment modalities may benefit from chronic use of low dose opioid medications. This should be weighed against the risk of abuse and diversion. Use of a standardized Opioid Risk Tool should be considered.
2. Most experts world-wide advocate a maximum dose of 120 mg oral morphine equivalents daily (MED) to decrease the risk of overdose and opioid-induced hyperalgesia. This does not mean doses should be escalated to this point in all patients. Many are well-controlled at lower doses. PHC recommends this 120 mg MED limit be used as a community standard. MED calculators are readily available online to convert any narcotic dose to its morphine equivalent. A good one is available at http://www.globalrph.com/narcotic.cgi. When patients already at 120 mg MED report insufficient pain control, the dose of opioids should not be increased further. A frank discussion with the patient on the risks of doing so should be conducted.
3. Other treatment modalities should be considered (if not previously utilized), including acupuncture, PT, massage, exercise, counseling, etc.
4. In neuropathic chronic pain, consideration should be given to the use of agents such as tricyclic antidepressants (e.g. amitriptyline or nortriptyline) and anticonvulsants (e.g. gabapentin or carbamazepine).
5. Emphasis should be placed on functional status as opposed to complete elimination of pain, which is often not possible.
6. For patient safety, intramuscular and intravenous opioids should not be administered for chronic, non-cancer, non-terminal pain.

D. Chronic non-cancer, non-terminal pain already on opioid doses greater than 120 mg MED.

1. Should not have their opioid dose increased further.
2. Should have their opioid dose decreased, by one of the following methods:
    a. Steady tapering of dose to 120 mg MED or lower. The exact tapering protocol will depend on the medication used, the dosage, and other factors.
    b. Substitution with buprenorphine (Suboxone) by a prescriber experienced in the use of this mediation
    c. Combination of the above with involvement of a multidisciplinary team, including behavioral health and physical therapy, and non-opioid medication options. The goal is to optimize functional status as opposed to complete alleviation of pain as the latter is often not possible.
    d. Reducing the opioid dose to a safer range can be time-consuming, and it requires both a discussion with the patient about the reasons why this reduction is needed and a clear, well-communicated plan for how this will happen. It is not advisable to allow the patient to decide whether to remain on an unsafe opioid doses. It should be mandatory. Whatever the policy around marijuana, if it is implemented clinic-wide and regionally, then patients will not be able to switch to a different clinician who would allow continued unsafe dosing.
    e. In larger practices or in communities, consider establishing a “chronic pain review committee” to review cases where greater than 120 mg MED are requested, if other exceptions to the institutional policy are considered, and to review clinical management of difficult cases. This helps support clinicians with responding to difficult patients and gives good support for peer review, if a patient has an adverse outcome.

E. <u>Routine monitoring of patients on chronic opioid therapy</u>. The following monitoring standards for patients on opioid therapy should be used by all clinicians in PHC regions.

1. Have a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
2. Have a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
3. PHC recommends clinicians have a policy which explicitly addresses the use of marijuana in chronic pain when opioids are to be prescribed. Increasingly, pain specialists and PCP practices ask patients to choose between opioids or marijuana for chonic pain. If the patient wants to use medical marijuana for chonic pain, they are not prescribed opioids and if they are prescribed opioids, their tox screens are expected to be negative for marijuana. If the community agrees on this standard, it will minimize patients switching to a different clinician in hopes of finding a different approach.
4. Regularly check the CURES database in all patients being prescribed opioids, preferably each time a prescription is being authorized. At a minimum, the CURES database should be checked annually. If a finding on the CURES report is not consistent with the patient's history, PHC recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.
5. Have at least three office visits yearly for chronic pain patients using opioids.
6. Limit each opioid prescription to 28 days (exactly four weeks), writing this on the prescription (e.g. "must last 28 days"). Writing for a 28-day quantity and making sure this is scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, reduces the problems of refills being sought on weekends or holidays, and requests for early refills because the patient will be running out on a weekend day (which will happen frequently if prescriptions are written for a 30-day supply).
7. Develop an office policy on consequences of breaches in the medication use agreement. Consider a tiered approach, depending on the breach. Examples of different tiers include: warning, modification of prescription frequency, reduced dosage of medication, cessation of medication, and discharge from practice.
8. Monitor for sedation that would make driving motor vehicles unsafe, particularly if opioids are combined with other sedating medications, alcohol, or other substances. If the patient is potentially unsafe to drive a motor vehicle, recommend to the patient they not drive if impaired and consider reporting the patient to the Department of Motor Vehicles (DMV) for evaluation. Note that a stable dose of opioid alone has not been shown to decrease reaction time, but if a patient is involved in a motor vehicle accident while taking an opioid, the use of the opioid may be used by law enforcement or attorneys to attribute blame. At times prescribers have come under fire in situations like this.
9. Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See www.prescribetoprevent.com for details.
10. Partnership HealthPlan as the capacity to restrict an individual patient to using a single pharmacy and a single prescriber for controlled medication. This is done at the request of the physician. If you have a patient you would like to request restricted status, call the pharmacy department at PHC at 707-419-7906, and we will initiate the process.

Example of Maximum Daily Recommended Oral Doses of Opioids

(120 mg MED)
(For chronic, non-cancer pain)
(Before use of any comparative dose data for patient use, please refer to listed reference below for dosing calculator)

Drug (Generic Name)	Mg	Low Cost Generic Available?	Brand Name Examples
Morphine (PO) Chronic	120	Yes	MS Contin, Avinza (Long Acting)
Codeine (PO)	400	Yes	
Fentanyl Transdermal	50mcg/hr	Yes	Duragesic (continuous release patch)
Hydrocodone (PO)	60	Yes	Vicodin, Norco (short acting only)
Hydromorphone (PO)	15-30	Yes	Dilaudid (short acting)
Levorphanol (PO) Chronic	4	Yes	LevoDromoran
Methadone (PO) Chronic	15	Yes	
Oxycodone (PO)	40-80	Short Acting:yes Long acting: no	Oxycontin (long acting)
Oxymorphone (PO)	20-40	No	Opana, Numorphan (short acting generic available but not low cost)
Tapentadol (PO)	150-200	No	Nucynta

http://www.globalrph.com/narcotic.htm

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Community Pharmacy Guidelines

Key Points from Other Guidelines

1. Emergency Departments should
   a. Check a CURES report on every patient who will receive an opiate prescription.
   b. Limit use of opioids for acute pain, especially if there a high risk of abuse and in adults under the age of 25.
   c. Limit opiate prescriptions to 4 days duration.
   d. Notify the PCP when an opiate is prescribed.
2. Dental Guidelines
   a. Use NSAIDs instead of opioids for dental pain (opioids no better than placebo).
3. Community Pharmacies should
   a. Check a CURES report for all new opioid prescriptions.
   b. Notify the PCP if there is a prescription pattern suggesting abuse or misuse.
   c. Check the photo ID of any patient picking up an opioid prescription.
   d. Counsel patients on the risk of tolerance, addiction, opiate-induced hyperalgesia, and drug overdose.

References

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Appendix A

Date ______________________

Patient Name ________________________

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	____	____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk $\geq$ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

Why we have shared responsibility to ensure safe opioid prescribing!

Functional Pain Scale

(developed by Kaiser Health Plan)