Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

Utah Department of Health
Utah Medical Association
2018

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The Utah Department of Health and the Utah Medical Association with the Opioid Prescribing Guidelines Advisory Committee are pleased to provide an updated copy of the "Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain." This document represents the results of many months of work on the part of many people, all of whom contributed considerable time, effort, experience, and expertise. This effort is an attempt to address a continually pressing and challenging public health problem- premature deaths, dependency and disability associated with misuse and/or abuse of prescription drugs, especially, narcotic medications.

In recent years, prescription medications used alone, in combination, or mixed with illicit drugs, have resulted in the death of hundreds of our fellow citizens. Utah has the 7th highest drug poisoning death rate in the nation (2013-2015) and disturbingly, the majority of overdose deaths in Utah involve opioids. **Since 2007, more deaths have resulted from prescription opioids than motor vehicle traffic crashes in our state. In fact, poisoning is the number one cause of unintentional deaths.** Given the high number of deaths associated with prescription opioids, understanding the role of opioid prescribing is vital to patient safety.

These guidelines are meant to be just that – suggestions on how to properly use and prescribe opioid medication. As with any effort to achieve consensus, there were members who participated in the preparation of this document who disagree at both ends of the spectrum, i.e., some believe that the guidelines are too lax, others believe they impose barriers to access of much needed narcotic medications for the control of pain. It is our hope that the guidance in this document will educate both the public and clinicians about appropriate use of these medications which will, if followed, significantly reduce deaths from misuse and abuse, but at the same time allow for the control of chronic pain with proper use of opioid medications.

I want to thank the many individuals and organizations that contributed to the preparation of this document. Countless hours were spent in meetings and in reviewing related literature. I particularly want to acknowledge the outstanding work of Anna Fondario, Program Manager in the Violence and Injury Prevention Program, and Marcelle Smith, Education Project Manager at the Utah Medical Association. I would also like to acknowledge that the Utah State Legislature mandated the Department of Health to "update the department's Utah Clinical Guidelines on Prescribing Opioids and promote its use by prescribers and dispensers of opioids" and provided the necessary resources.

I'm hopeful that these guidelines will continue to prove to be a "living document" that will be updated over time to reflect new knowledge and science and thereby improve the public's health in our state.

Sincerely,

Joseph K. Miner, MD

Joseph Miner, MD
Executive Director

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The Utah Department of Health is grateful for the leadership of by Representative Mike K. Mckell who introduced House Bill 192: Opiate Overdose Response Act – Pilot Program and Other Amendments, which were passed during the 2016 Utah General Legislative Session, providing funds and direction for the update of these guidelines.

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Disclosure of Funding

These guidelines are based on research conducted at the Utah Department of Health with funding from the Utah State Legislature. In addition, this publication was supported by the Grant or Cooperative Agreement Number, 6 NU17CE92733-02-01, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Statutory Authority

These guidelines were authorized by the Utah Legislature which directed the Utah Department of Health to "update the department's Utah Clinical Guidelines on Prescribing Opioids and promote its use by prescribers and dispensers of opioids" (§26-55-107 Utah Code Annotated).

Disclosure of Conflicts

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Background and Introduction

Unintentional fatalities due to prescription medications are an increasing problem in the United States and Utah. In the year 2000, the Utah Medical Examiner noted an increase in the number of deaths occurring due to an overdose of prescription opioid medications that are typically used for pain management. Epidemiologic studies conducted in Utah using death certificate data, Office of the Medical Examiner data, emergency department encounter data, and data from the Utah Controlled Substances Database confirmed the increases and uncovered an alarming problem.

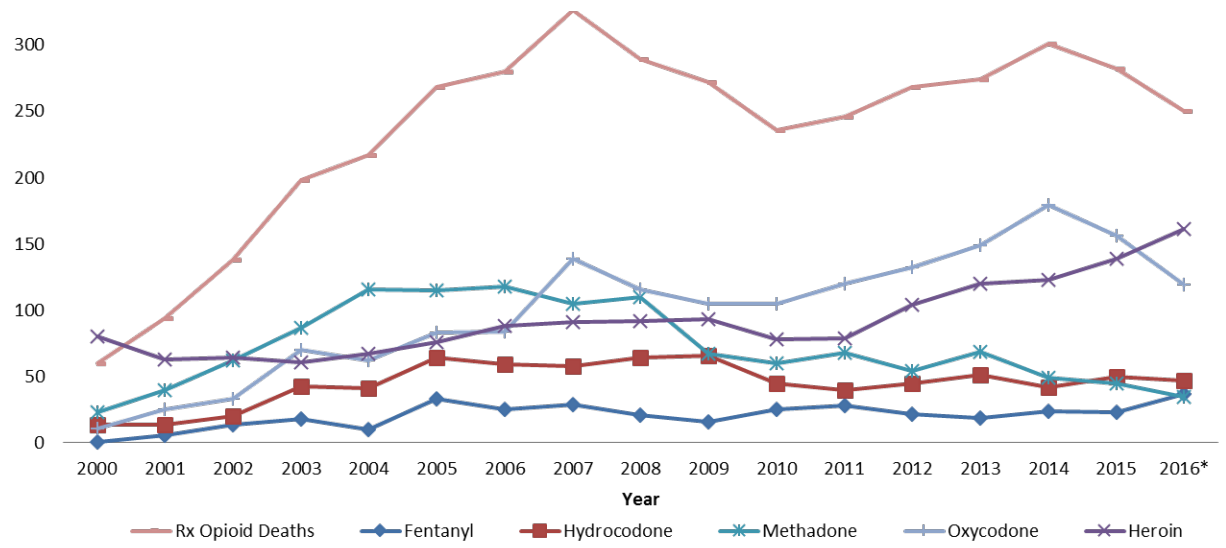
During the years 2000-2016, deaths in Utah attributed to poisoning by prescription pain medications increased by over 300%, from 60 to 250. Deaths of Utah residents from non-illicit drug poisoning (unintentional or intent not determined) increased from about 61 deaths per year in 2000 to over 253 in 2016. In the past, the increase was mostly due to an increase number of deaths from prescription opioid pain medications, including methadone, oxycodone, hydrocodone, and fentanyl (CDC, 2005). Public health efforts have modestly decreased the number of deaths for certain prescription opioids, however; a recent increase in deaths due to heroin and synthetic opioids other than methadone (namely from illegally manufactured fentanyl) have been observed (CDC, 2016 www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm).

In 2016, recognizing the continued need for intervention, the Utah State Legislature passed House Bill 192 appropriating funding to the Utah Department of Health (UDOH) to establish a program aimed at reducing deaths and other harm from prescription opioids. Additionally, the bill directed the UDOH to update the Utah Clinical Guidelines on Prescribing Opioids and promote its use by prescribers and dispensers of opioids.

A key goal of these guidelines is to seek a balance between appropriate treatment of pain and safety when using opioids for that purpose. The Model Policy for the Use of Controlled Substances for the Treatment of Pain[1] (Federation of State Medical Boards, 2013) acknowledged that "undertreatment of pain is… a serious public health problem," but also sought to establish the importance of balance in treating pain as stated in the following sentence:
"…inappropriate treatment of pain includes non-treatment, inadequate treatment, overtreatment, and continued use of ineffective treatments."

[1] The Model Policy for the Use of Controlled Substances for the Treatment of Pain was developed by the Federation of State Medical Boards and endorsed by the Division of Occupational and Professional Licensing on recommendation of the Physicians Licensing Board.

Figure 1: Number of Unintentional and Undetermined Opioid Overdose Deaths, Utah 2000-2016



The principal focus of these guidelines is to provide recommendations on how to safely and effectively treat acute and chronic pain with less risk of overdosing. The guidelines also include several recommendations to help minimize diversion of opioid medications to non-medical. The guidelines were not developed to guide the treatment of patients with malignant cancer or patients in hospice or palliative care settings.

Medicine is practiced one patient at a time and each patient is unique with individual needs and vulnerabilities. The guidelines are an attempt to guide clinicians, not to inappropriately constrain practice. However, these guidelines were based on evidence or consensus recommendations by healthcare, medical, pain, and public health experts. They are intended to improve outcomes of patient care and to prevent deaths due to opioid use.

Summary of Recommendations for Prescribing Opioids

Opioid Treatment for Acute Pain

1. Use alternative treatments to opioids
2. Check the Utah Controlled Substance Database
3. Consider patient risks
4. Prescribe immediate-release/short-acting opioids (IR/SA)
5. Prescribe the lowest effective dose
6. Avoid combining opioids with CNS depressants
7. Counsel patients on the risks of opioids

Opioid Treatment for Chronic Pain

Prior to Prescribing Opioids (1.1-3.3)

- 1.1 Use alternative treatments to opioids
- 1.2 Identify if benefits outweigh the risks
- 2.1 Complete a comprehensive patient evaluation
- 2.2 Check disease-specific guidelines
- 3.1 Screen for risk of opioid use disorder
- 3.2 Obtain a urine drug screen
- 3.3 Check the Utah Controlled Substance Database

Establish Treatment Goals and a Written Treatment Plan (4.1-5.2)

- 4.1 Establish a written treatment plan
- 4.2 Identify measurable treatment goals
- 4.3 Maintain accurate patient records
- 4.4 Plan to modify or discontinue opioid therapy
- 5.1 Obtain signed informed consent form
- 5.2 Educate patient and family/caregivers

Initiating and Adjusting Opioid Treatment (6.1-6.7)

- 6.1 Combine therapies
- 6.2 Initiate short-term treatment trial
- 6.3 Begin with immediate-release/short-acting opioids (IR/SA)
- 6.4 Prescribe the lowest effective dose
- 6.5 Prevent prescription fraud
- 6.6 Implement dose titration and re-evaluation
- 6.7 Avoid parenteral opioids

Mitigating risks (7.1-7.7)

- 7.1 Avoid combining opioids with CNS depressants
- 7.2 Evaluate risks associated with sleep apnea
- 7.3 Obtain urine drug screens
- 7.4 Check the Utah Controlled Substance Database
- 7.5 Co-prescribe naloxone
- 7.6 Provide overdose education and counseling
- 7.7 Counsel patients on safe storage, disposal, and diversion

Treatment Management (8.1-10.2)

- 8.1 Monitor opioid therapy
- 8.2 Evaluate patient progress
- 8.3 Adjust and prescribe medication during clinic visit
- 9.1 Obtain a second opinion or consultation
- 9.2 Refer to a substance use disorder specialist for treatment
- 9.3 Offer medication-assisted treatment
- 9.4 Refer to mental health services
- 10.1 Discontinue treatment in certain conditions
- 10.2 Safely taper or refer to treatment

Methods

Purpose and Target Audience

These guidelines provide recommendations for the use of opioids for management of pain that are intended to balance the benefits of use against the risks to the individual and society. The target audience for these guidelines includes all clinicians who prescribe opioids in their practice[2].

Advisory Committee Composition

The Utah Department of Health and the Utah Medical Association convened an Advisory Committee (see page i, Acknowledgements, for a complete list of committee members)to review the guidelines and provide appropriate edits. The Advisory Committee convened between May and June 2017. Each member signed a Conflict of Interest disclosure form and conflicts were reported (See Disclosure of Conflicts on page ii). The Advisory Committee consisted of 15 experts throughout the state of Utah.

Guideline Development Process

The guidelines are a compilation of the 2009 "Utah Clinical Guidelines on Prescribing Opioids for the Treatment of Pain" and the "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016." Both the 2009 Utah Guideline and the 2016 CDC Guidelines development involved thoroughly researching evidence-based opioid guidelines; rating guidelines based on quality of evidence and strength of recommendations, including top guidelines in the final draft; and enlisting the expertise of professionals to review and finalize the guidelines. The development of the 2018 Utah Clinical Guideline began with studying the 2009 Utah Guidelines and the 2016 CDC Guideline. Certain recommendations from the 2016 CDC Guidelines were added to the 2009 Utah Guidelines to form an updated 2018 Utah Guidelines draft. The draft was then reviewed by physicians and other experts on the Advisory Committee, and feedback was incorporated into the final version.

[2] In Utah, as of January 2009 (R156-37), clinicians who can be licensed to prescribe controlled substances as part of practice (human) includes physicians and surgeons, osteopathic physicians and surgeons, podiatrists, dentists, physician assistants, advanced practice registered nurses, certified nurse midwives, certified nurse anesthetists, and optometrists.

Recommendations for Acute and Chronic Pain

***Preface**: The purpose of this document is to improve outcomes in the treatment of pain and to reduce opioid-related morbidity and mortality. These recommendations refer to clinical circumstances where patients may be provided with a prescription for opioid analgesics.*

Acute Pain Opioid Treatment Recommendations

Acute Pain Recommendation 1: Use Non-pharmacologic and Non-opioid Pharmacologic Therapies as Alternative Treatments to Opioids

Opioid medications should only be used for the treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies are either contraindicated or will not provide adequate pain relief. Unless contraindicated, non-opioid analgesics, adjuvant analgesics (e.g., anticonvulsants, antidepressants, non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids) and non-pharmacologic therapies (e.g., cognitive behavioral therapy, physical therapy) are the preferred method of treatment of acute pain.

Most acute pain can be effectively and safely treated with non-pharmacologic or non-opioid therapies (e.g., acetaminophen, non-steroidal anti-inflammatory drugs [NSAIDs], or therapies such as exercise, or specific stretching) rather than opioid medications, which have less desirable adverse effects. Care should be taken to assure that use of opioid pain treatment does not interfere with early implementation of functional restoration programs, such as exercise and physical therapy.

Acute Pain Recommendation 2: Check the Utah Controlled Substance Database (CSD)

The CSD should be checked before prescribing opioids for acute pain to learn more about the patient's controlled substance prescription history at the inception of a patient-prescriber relationship and when prescribing opioids. Document the results of this review in the patient's record.

The Utah Division of Occupational and Professional Licensing (DOPL) maintains the CSD Program. Access to the data is provided to authorized individuals by going online at www.dopl.utah.gov. Individuals who are licensed to prescribe controlled substances in Utah or staff assigned by the prescriber must register with DOPL to use the CSD. A prescriber can designate one or more employees who can access the CSD on the prescriber's behalf.

Information from the CSD may be included in a patient's medical chart or file and shared with other medical professionals authorized to receive the information pursuant to Utah law and HIPAA.

Utah law requires a prescriber to check the database before the first time the prescriber issues a Schedule II or III opioid prescription. A prescriber is also required to check the database or similar records if the prescriber is repeatedly prescribing Schedule II or III opioids to a patient. Exceptions include when it is 1) necessary due to an emergency situation; 2) caused by a suspension or

disruption in the database operation; or 3) caused by failure or availability of the internet. Utah Code Ann 58-37f-304(2).

The following controlled substances are not *required* to be reported in the CSD:

- Prescriptions filled at federal facilities, such as military facilities. The Veteran's Administration provides data in accordance to Public Law 115-86 115th Congress.
- Prescriptions filled for individuals by pharmacies located outside the State of Utah.
- Controlled substances administered in an inpatient setting.

Acute Pain Recommendation 3: Consider Patient Risks

Proactively consider initial and ongoing risks associated with opioid exposure based on age of the patient; history of substance use disorder; or psychiatric, physical, or medical comorbidities.

The developing brain may be more susceptible to addiction when exposed to opioid medications and nonmedical use is more common among younger people. Those risks should be considered when prescribing to an adolescent[3].

Patients with mental health conditions are at increased risk for developing chronic pain; therefore, physicians should be cognizant of a patient's psychological status and potential for substance use disorder.

"Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, using validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the PHQ-4 to assess for anxiety, post-traumatic stress disorder, and/or depression (*205*), might help prescribers improve overall pain treatment outcomes. Experts noted that prescribers should use additional caution and increased monitoring to lessen the increased risk for opioid use disorder among patients with mental health conditions (including depression, anxiety disorders, and PTSD), as well as increased risk for drug overdose among patients with depression[4]."

The **GAD-7** and **PHQ-4** and **PHQ-9** can be found in the **Tools and Resources** section.

Acute Pain Recommendation 4: Prescribe Immediate-release/Short-acting Opioids (IR/SA)

When opioids are indicated for the treatment of acute pain, prescribe immediate-release/short-acting (IR/SA) opioids. Extended-release/long-acting (ER/LA) opioids, including methadone, should rarely, if ever, be prescribed for acute pain, including post-operative pain. Severe acute pain that persists longer than the expected healing time warrants re-examination.

[3] Utah Department of Health (2009). Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, p. 14. Salt Lake City, UT: Utah Department of Health.

[4] Centers for Disease Control and Prevention [Patients with Mental Health Conditions]. MMWR 2016; 65(No.1): [27].

Patients with acute pain who fail to recover in a usual timeframe or otherwise deviate from the expected clinical course for their diagnosis should be carefully evaluated. The continuation of opioid treatment in this situation may represent the initiation of opioid treatment for a chronic pain condition. The diagnosis and appropriateness of interventions should be re-evaluated and the patient's medical history should be reviewed for comorbidities that could interact with opioid treatment and for risk factors during opioid treatment, including current or history of substance use disorder. It is also recommended that the prescriber check the Utah Controlled Substance Database at the time they prescribe an opioid.

Acute Pain Recommendation 5: Prescribe the Lowest Effective Dose

When opioid medications are prescribed for treatment of acute pain, prescribers should prescribe the lowest effective dose and no more than the number needed for the usual duration of pain associated with that condition, usually 3-5 days and rarely more than seven days.

Utah law states, "an opiate…issued for an acute condition shall be completely or partially filled in a quantity not to exceed a seven-day supply as directed on the daily dosage rate of prescription." The exceptions are when a prescription is 1) issued for a surgery and more is determined to be needed, in which case *up to* a 30-day supply may be prescribed; and 2) issued for complex or chronic conditions which are documented in the medical record. Utah Code 58-37-6 (7)(f)(iii).

Prescribing more medication than the amount likely to be needed leads to unused medications being available for abuse or diversion. Use of opioid pain medications should be stopped when pain severity no longer requires opioid medications and when function and quality of life has improved.

Acute Pain Recommendation 6: Avoid and Counsel Against Combining Opioids with CNS Depressants

Avoid prescribing, and counsel against, concurrent use of opioids and benzodiazepines. Patients should also be counseled against concurrent use of opioids with other sedating substances, including alcohol muscle relaxant drugs, and sedative hypnotics including prescription and over-the-counter sleep aids, etc.

Concurrent use of alcohol, benzodiazepines, and other CNS depressants increases the risk of respiratory depression, which can potentially cause death. Concurrent use of benzodiazepines requires explicit medical justification due to the serious risk of respiratory depression. For putative psychiatric indications, psychiatric consultation should be sought to treat the patient's condition with potentially less toxic drug-to-drug interactions. Prescribers should warn patients of the high-risk interaction of opioids and CNS depressants.

Acute Pain Recommendation 7: Counsel Patients on the Risks of Opioid

The patient should be counseled on the risks of taking opioids that including dependency, addiction, and death. In addition, patients should be advised of the signs of an opioid overdose and informed of

the availability of naloxone. Patients should be encouraged to securely store their medications, not share with others, and to dispose of opioids properly when the pain has resolved to prevent non-medical use of the medications.

Patients and family/caregivers should learn to recognize the signs of an opioid overdose:

- Extremely pale face and/or feels clammy to the touch
- Body goes limp
- Fingernails or lips have a purple or blue color
- Vomiting or making gurgling noises
- Unable to be awakened or unable to speak
- Breathing or heartbeat slows or stops

For patient education materials and resources on the risks of taking opioids and signs of an opioid overdose, visit www.opidemic.org. For information on safe storage and disposal, visit www.useonlyasdirected.org. For information on naloxone information, visit naloxone.utah.gov.

Chronic Pain Opioid Treatment Recommendations

Prior to Prescribing Opioids (1.1-3.3)

Chronic Pain Recommendation 1: Assessment

Chronic Pain Recommendation 1.1: Use Non-pharmacologic and Non-opioid Pharmacologic Therapies as Alternative Treatments to Opioids

Opioid medications should only be used for treatment of chronic pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies are either contraindicated or will not provide adequate pain relief. Unless contraindicated, non-opioid analgesics, adjuvant analgesics (e.g., anticonvulsants, antidepressants, non-steroidal anti-inflammatory drugs [NSAIDs], corticosteroids) and non-pharmacologic therapies (e.g., cognitive behavioral therapy, physical therapy) are the preferred method of treatment of chronic pain.

Opioid medications are not the appropriate first line of treatment for most patients with chronic pain. Other non-pharmacologic and non-opioid pharmacologic therapies, should be tried and the outcomes of those therapies documented first. Opioid therapy should be considered only when other potentially safer and more effective therapies are proven inadequate. Care should be taken to assure that use of opioid pain treatment does not interfere with early implementation of functional restoration programs, such as exercise and physical therapy.

Chronic Pain Recommendation 1.2: Identify if Benefits Outweigh the Risks

Proactively consider initial and ongoing risks associated with opioid exposure based on age of the patient, history of substance use disorder, or psychiatric, physical, or medical comorbidities. Prescribers should only consider opioid therapy for a patient when expected benefits of pain improvement, function, and quality of life are anticipated to outweigh the risks.

Identify if benefits outweigh the risks by completing recommendation sections 2. Comprehensive Evaluation and 3. Screening for Risk of Substance Use Disorder and by determining desired treatment outcomes.

Chronic Pain Recommendation 2: Comprehensive Evaluation

Chronic Pain Recommendation 2.1: Complete a Comprehensive Patient Evaluation

A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain.

The comprehensive evaluation consists of the patient's social/work history, medical history, mental health/substance use history, and physical examination. The goal of the comprehensive evaluation is to determine the nature of the patient's pain; evaluate how the pain is impacting the patient's job requirements, activities of daily living, and quality of life; identify other conditions or circumstances that could affect the choice of treatment or the approach to managing that treatment; assess and evaluate prior approaches to pain management; and serve as a basis in establishing a treatment plan and evaluation of treatment outcomes.

For more specific information about what the comprehensive evaluation includes, see the Tools and Resources section.

Chronic Pain Recommendation 2.2: Check Disease-specific Guidelines
Prescribers should refer to disease-specific guidelines for recommendations of treatment for specific diseases or conditions of chronic pain.

Chronic Pain Recommendation 3: Risk of Substance Use Disorder Screening

Chronic Pain Recommendation 3.1: Screen for Risk of Opioid Use Disorder
Use a validated screening tool to assess the patient's risk of opioid use disorder prior to prescribing an opioid medication long-term for chronic pain.

Long-term use of opioid medications to treat chronic pain safely requires the commitment of adequate resources to regularly monitor and evaluate outcomes and identify occurrence of adverse consequences. The screening tool results are intended to assist the prescriber in determining whether opioid therapy is appropriate and in determining the level of monitoring appropriate for the patient's level of risk.

Prescribers may use one of the standardized screening forms to help determine personal and family risks:

- Patient Health Questionnaire (PHQ-4) or (PHQ-9)
- Opioid Risk Tool (ORT©)
- Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R®)
- Current Opioid Misuse Measure (COMM®)
- Alcohol, Smoking, and Substance Screening Test (ASSIST)

These forms can be found in the **Tools and Resources** section.

Chronic Pain Recommendation 3.2: Obtain a Urine Drug Screen
Urine drug screening is strongly recommended before initiating opioid treatment for chronic pain.

Research and experience have shown that drug testing can identify problems, such as use of undisclosed medications, non-use of reported medications (i.e., drug hoarding or diversion), undisclosed use of alcohol, or use of illicit substances. It is recommended that drug testing be conducted, especially when other factors suggest a patient is at risk for opioid misuse, abuse, or overdose. If the condition started with acute pain and there is consideration for chronic use, at least one drug screen in approximately 1-2 months is advised.

A positive drug screen indicates the need for caution, but does not preclude opioid use for treatment of pain. Consideration should be given to referring the patient to substance abuse counseling and/or to

a pain management specialist. If urine drug screening is positive for drugs that were not prescribed, are illegal, or for the absence of the prescribed meds, document this in the patient's record and counsel the patient about adherence to a drug treatment plan or initiating a drug contract.

Chronic Pain Recommendation 3.3: Check the Utah Controlled Substance Database (CSD)
The CSD should be checked at the inception of a patient-prescriber relationship and before prescribing opioids for chronic pain to learn more about the patient's controlled substance prescription history. Document the results of this review in the patient's record.

The Utah Division of Occupational and Professional Licensing (DOPL) maintains the CSD Program. Access to the CSD is provided to authorized individuals by going online at www.dopl.utah.gov. Individuals who are licensed to prescribe controlled substances in Utah or staff assigned by the prescriber must register with DOPL to use the CSD. A prescriber can designate one or more employees who can access the CSD on the prescriber's behalf.

Recently passed Utah law requires a prescriber to check the database before the first time the prescriber issues a Schedule II or III opioid prescription, unless the prescription is for three or fewer days, the prescriber has prior knowledge of the patient's prescription history, or it is a post-surgical prescription written for a duration of 30 days or less. A prescriber is also required to check the database or similar records if the prescriber is repeatedly prescribing Schedule II or III opioids to a patient (Utah Code Ann 58-37f-304(2)(b).

Information from the CSD may be included in a patient's medical chart or file and shared with other medical professionals authorized to receive the information pursuant to Utah law and HIPAA.

The following controlled substances are not *required* to be reported in the CSD:

- Prescriptions filled at federal facilities, such as military facilities. The Veteran's Administration provides data in accordance to Public Law 115-86 115th Congress.
- Prescriptions filled for individuals by pharmacies located outside the State of Utah.
- Controlled substances administered in an inpatient setting.

Establish Treatment Goals and a Written Treatment Plan (4.1-5.2)

Chronic Pain Recommendation 4: Goals and Treatment Plan

Chronic Pain Recommendation 4.1: Establish a Written Treatment Plan
A patient-provider collaborative written opioid treatment plan should be established before opioid therapy and be reviewed and updated on a regular basis.

Prescribers should tailor the treatment goals to the patient's circumstances, cultural perferences, and to the characteristics and pathophysiology of the pain. The pathophysiologic basis of the pain can help establish a prognosis for future improvement (or worsening) in function and pain, and should influence the treatment goals. Non-opioid treatment modalities should be included in the treatment plan whenever possible to maximize the likelihood of achieving treatment goals.

Patient responsibilities include properly obtaining, filling, and using prescriptions as directed, and adherence to the treatment plan. The treatment plan is usually combined with the a consent form. See Recommendation 5.1 for more information.

A sample treatment plan can be found in the **Tools and Resources** section.

Chronic Pain Recommendation 4.2: Identify Measurable Treatment Goals
Treatment goals should include measurable goals for function, quality of life, and improved pain control and should be developed jointly by the patient and prescriber.

Prescribers have observed and adherence literature confirms that when patients are engaged in their own healthcare and assume responsibility for their rehabilitation, they are more likely to improve; and that when they participate in goal setting, they are more likely to achieve their goals. As with any other chronic illness (e.g., diabetes or heart disease), the prescriber should focus not just on pain control, but also on treating the patient's underlying diseases and encouraging them to engage in the full spectrum of their health.

These measures of improvement or worsening can be reported by the patient, family members, and/or employer. Permission to discuss the patient's condition with these persons should have previously been obtained and documented.

Chronic Pain Recommendation 4.3: Maintain Accurate Patient Records
Prescribers should obtain and document information about the patient's treatment and history.

Prescribers should document the treatment, interactions, and findings throughout their professional relationship with the patient. Providing thorough documentation throughout the treatment plan is essential for patient safety and prescriber protection.

Chronic Pain Recommendation 4.4: Plan to Modify or Discontinue Opioid Therapy
The treatment plan and goals should explicitly include a plan to modify or discontinue opioid therapy when benefits do not outweigh the risks or when the patient fails to adhere to the agreed upon treatment plan.

Prescribers should evaluate benefits and harms with patient within 1-4 weeks of starting opioid therapy or at the time of dose escalation; then continue to evaluate the benefits and harms of therapy with the patient every three months or more frequently if needed. If the benefits do not outweigh the harms of continued opioid therapy, prescribers should optimize other therapies and work with the patient~~s~~ to taper opioids to lower dosages or to taper and discontinue opioids[5]. (See Chronic Recommendation 10.2)

Chronic Pain Recommendation 5: Informed Consent

Chronic Pain Recommendation 5.1: Obtain Signed Informed Consent Form
Prescribers should discuss with patients the known risks and realistic benefits of opioid therapy and patient and prescriber responsibilities for managing therapy, including any conditions for continuation of opioid treatment. This discussion should be documented using a written and signed informed consent form, which is often combined with the treatment plan.

The informed consent form typically includes information about the:

- Potential risks and benefits of controlled substance use, including the risk of misuse, dependence, addiction, overdose, and death
- Adverse effects
- Likelihood of tolerance and dependence developing
- Possible drug interactions and risk of over-sedation
- Limited evidence of the benefit of long-term opioid therapy
- Risk of impairment while operating motor vehicles or equipment or performing other tasks
- Prescriber's policies and expectations
- Specific reasons for adapting or discontinuing opioid therapy

Informed consent should also include explaining to patients that they should not expect complete relief of their pain. Improved function is the main criterion for continuing opioid treatment.

Chronic Pain Recommendation 5.2: Educate Patient and Family/Caregivers
Educational material about the patient's opioid treatment plan should be provided in written form and discussed in person with the patient and, when applicable, the patient's family or caregivers.

For patient education materials and resources on the risks of taking opioids and signs of an opioid overdose, visit www.opidemic.org. For information on safe storage and disposal, visit www.useonlyasdirected.org. For information on naloxone information, visit naloxone.utah.gov.

[5] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016.65(No. 1):[27]

Discuss with the patient the involvement of family and caregivers in their care and receive written permission from the patient to involve the family or caregivers. This is best done before starting to treat the patient, because it can be more difficult to obtain consent after an issue occurs.

Utah Code Section 58-37f-301(5) allows a person for whom a controlled substance is prescribed to designate a third party who will be notified by DOPL when a controlled substance is dispensed to the individual. The controlled substance is not identified in the notification. This person may also direct the division to discontinue providing information to the designated party, in which case the designee will be notified. Prescribers should discuss this designation with patients.

Note: Consultation with others, in the absence of consent, must be done within the guidelines and constraints of HIPAA.

Initiating and Adjusting Opioid Treatment (6.1-6.7)

Chronic Pain Recommendation 6: Opioid Treatment Trial

Chronic Pain Recommendation 6.1: Combine Therapies
When opioid treatment is indicated, non-opioid analgesics, adjuvant analgesics, and non-pharmacologic therapies should be used in combination with opioid treatment as appropriate for the patient.

Combination products with opioid and non-opioid analgesics may result in better pain relief than either drug alone, but the opioid dose is limited by the non-opioid. The use of adjunctive medications, as well as other therapies, such as physical therapy, exercise, stretching, and other alternative therapies, can reduce the dose of opioid needed for adequate pain relief; and consequently, improve a patient's functionality.

Chronic Pain Recommendation 6.2: Initiate Short-term Treatment Trial
Opioid medication should be initiated as a short-term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life.

The prescriber should clearly explain to the patient that initiation of opioid treatment is not a commitment to long-term opioid treatment and that treatment will be stopped if the trial is determined to be unsuccessful. The trial should be for a specific time period with pre-determined evaluation points as defined in the treatment plan measures. The decision to continue opioid medication treatment beyond the trial period should be based on the balance between benefits gained in function and quality of life, and adverse effects experienced. Criteria for cessation should be determined before treatment begins.

When a *new patient* has already been receiving opioid therapy for a chronic condition, the same recommendations apply: assess the patient's chronic pain, complete a comprehensive evaluation, screen for risk of substance use disorder, establish a treatment plan and informed consent, initiate treatment trial, mitigate risks, and consider a multi-disciplinary approach. The evaluation process may require more time than the initial appointment, so the prescriber must use their professional judgement if opioids are deemed necessary. If opioid treatment is necessary, it is suggested that the dose be limited and only long enough to complete an adequate evaluation and to seek consultation, as needed.

Chronic Pain Recommendation 6.3: Begin with Immediate Release/Short-Acting (IR/SA)
The trial should begin with immediate-release/short-acting (IR/SA) opioid medication.

Immediate-release, short-acting (IR/SA) opioid medications are generally safer and easier to titrate to an effective dose. CDC experts agreed that for patients not already receiving opioids, prescribers

should not initiate opioid treatment with extended-release/long-acting opioids (ER/LA) and should not prescribe ER/LA opioids for intermittent use.

ER/LA opioids should be reserved for severe continuous pain and should be considered only for patients who have received IR/SA opioids daily for at least one week. Initial treatment should not use methadone, fentanyl, or the combination of opioids and benzodiazepines.

Chronic Pain Recommendation 6.4: Prescribe the Lowest Effective Dose
When opioids are prescribed for the treatment of chronic pain, prescribers should prescribe the lowest effective dose. Prescribers should use caution when prescribing opioids at any dosage, should carefully re-assess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

The CDC states that although there is not a single dosage threshold below which overdose risk is eliminated, holding dosages below 50 MME/day would likely reduce risk among most patients who would experience fatal overdose at higher prescribed dosages. Utilization of any dose should be based on incremental functional gains.

Benefits of high-dose opioids for chronic pain are not established. At the same time, risks for serious harm increase at higher opioid doses. Opioid overdose risk increases in a dose-response manner. Dosages of 50-100 MME/day increase risks for opioid overdose by 1.9-4.6 times and dosages ≥ 100 MME increase risk by 2.0-8.9 times as compared with the risk at 1-20 MME/day[6].

Chronic Pain Recommendation 6.5: Prevent Prescription Fraud
The prescription for opioid therapy should be written on tamper-resistant prescription paper or e-prescribed to prevent prescription fraud.

To reduce the chance of tampering with the prescription, write legibly and keep a copy in your records. According to the Drug Enforcement Administration (DEA), all records related to controlled substances must be maintained and be available for inspection for a minimum of two years.

Chronic Pain Recommendation 6.6: Implement Dose Titration and Re-evaluation
Regular face-to-face visits with the patient and evaluation of progress against goals should be scheduled during the period when the opioid dosage is being adjusted. The opioid trial or long-term treatment should be continually evaluated for functional benefit and achievement of treatment goals, using appropriate tracking tools.

Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain and function. Monitoring progress toward patient-centered functional goals (e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational

[6] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016;65(No. 1):[23].

activities) can also contribute to the assessment of functional improvement. Prescribing providers should use these goals in assessing the benefits of opioid therapy for individual patients and in weighing benefits against risks of continued opioid therapy[7].

There are a variety of tracking tools that can be used to set and monitor treatment goals:

- Pain Assessment and Documentation Tool (PADT™)
- Brief Pain Inventory (BPI©)
- Treatment agreement
- Patient Health Questionnaire (PHQ-4 or PHQ-9)

These forms can be found in the **Tools and Resources** section.

Chronic Pain Recommendation 6.7 Avoid Parenteral Opioids

Parenteral (intravenous, intramuscular, or subcutaneous) administration of opioids for chronic pain is strongly discouraged, unless prescribing within an inpatient or palliative care setting.

Any circumstance warranting parenteral administration should be clearly justified by clinical exigencies (e.g., bowel obstruction, terminal care, etc.).

These guidelines do not consider intrathecal administration and this recommendation was not intended to discourage trained and qualified physicians from using intrathecal opioid medications when indicated.

Daily intramuscular (IM) or subcutaneous (SC) injections should be avoided except in a highly supervised environment, such as during an admission to the hospital or hospice.

[7] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016;65(No. 1):[20].

Mitigating risks (7.1-7.7)

Chronic Pain Recommendation 7: Risk Mitigation

Chronic Pain Recommendation 7.1: Avoid and Counsel Against Combining Opioids with CNS Depressants

Avoid prescribing, and counsel against, concurrent use of opioids and benzodiazepines. Patients should also be counseled against concurrent use of opioids with other sedating substances, including alcohol muscle relaxant drugs, and sedative hypnotics including prescription and over-the-counter sleep aids, etc.

Concurrent use of alcohol, benzodiazepines, and other CNS depressants increases the risk of respiratory depression, which can potentially cause death. Concurrent use of benzodiazepines requires explicit medical justification due to the serious risk of respiratory depression. For putative psychiatric indications, psychiatric consultation should be sought to treat the patient's condition with potentially less toxic drug-to-drug interactions. Prescribers should warn patients of the high-risk interaction.

Chronic Pain Recommendation 7.2: Evaluate Risks Associated with Sleep Apnea

Prescribers should assess the patient's risk for sleep apnea and strongly consider formal screening.

Risk factors for sleep-disordered breathing include congestive heart failure and obesity. Experts noted that careful monitoring and cautious dose titration should be used if opioids are prescribed for patients with mild sleep-disordered breathing. Prescribers should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing whenever possible to minimize the risk of opioid overdose[8].

Naloxone rescue medication should be provided to the family/caregivers, as well as education on when to administer naloxone if the patient has risk of sleep apnea, regardless of total daily dose of MME used.

Educating the family/caregivers about the signs of an opioid overdose may help detect problems before they lead to a serious complication. Patients and family/caregivers should learn to recognize the danger signs of respiratory depression and know to how to offer help and summon medical help immediately if a person demonstrates any of the following signs while on opioids:

Episodic cessation of breathing;

- Periods of irregular or other sleep-disordered breathing
- Extreme drowsiness and difficulty being awakened
- Slow, shallow breathing with little chest movement
- Increased or decreased heartbeat or palpitations
- Feeling faint, dizzy, or confused

[8] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016;65(No. 1):[26]

Chronic Pain Recommendation 7.3: Obtain Urine Drug Screens
Prescribers should perform drug screening on randomly selected visits and any time aberrant behavior is suspected.

A good practice is to give all patients taking chronic controlled substance prescriptions at least an annual urine tests and high-risk patients more frequent random urine tests with no advance notice. Drug testing has been shown to identify the presence of illegal drugs, unreported prescribed medication, unreported alcohol use, or the absence of the patient's prescribed medication. This assists the prescriber in determining whether the opioid therapy is appropriate and in determining the required frequency of monitoring. It also provides an opportunity to discuss the risks of opioid treatment. Random pill counts may also be useful.

Immunoassays can be done in the office. These screening tests determine if opioids are present but do not identify specific ones, which can subsequently be determined by confirmatory laboratory testing. However, in many cases, confirmation testing can be eliminated by carefully going over the results of the initial in-office test with the patient. Prescribers need to recognize that immunoassays have both false positive and false negative results. Over-the-counter medication, for example, can cause a positive result. Many synthetic opioids are not detected by urine immunoassay screening and require confirmation testing if suspected. The prescriber may want to consider confirmatory testing or consultation with a Certified Medical Review Officer if drug test results are unclear.

An abnormal drug screen should be specified in the treatment plan as a possible reason to cease treatment.

Chronic Pain Recommendation 7.4: Check the Utah Controlled Substance Database (CSD)
During treatment of chronic pain with opioid medications, the CSD should be checked at least quarterly.

Prescribers should review the patient's history of controlled substance prescriptions to determine whether the patient is receiving opioid dosages or dangerous combinations that put them at high risk for overdose. Prescribers should communicate with others managing the patient or prescribing controlled substances to coordinate care and to improve patient's safety.

Aberrant findings in the CSD (or from urine drug screening) necessitate a frank conversation with the patient. Such findings, based upon the treatment plan, may be cause for tapering/discontinuing controlled substances, referring the patient to a pain management specialist, or developing a new treatment plan.

Chronic Pain Recommendation 7.5: Co-prescribe Naloxone
As an intervention to prevent a potential opioid overdose death, co-prescribe an approved naloxone delivery kit for patients receiving opioids for treatment of chronic pain.

Prescribers should mitigate the risk of an opioid overdose by offering patients naloxone when increased opioid overdose risk factors are present, such as a history of overdose or substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use. Naloxone administration is intended to reverse life-threatening respiratory depression. Naloxone is commercially available by prescription for emergency use in autoinjector and intranasal administration forms.

See Chronic Pain Recommendation 7.6 for the duration of action of naloxone and additional information.

On December 8, 2016, the Utah Department of Health issued a standing order that pharmacists may dispense naloxone to concerned family members, caregivers, friends, and patients without a written prescription. However, pharmacies are not required to participate in the standing order.

For patient education materials and resources on naloxone, visit **naloxone.utah.gov**.

Chronic Pain Recommendation 7.6: Provide Overdose Education and Counseling
Provide the patient and family/caregivers information on the signs and symptoms of an opioid overdose, how to obtain naloxone, and the timely and proper administration of naloxone.

Patients and family/caregivers should learn to recognize the danger signs of an opioid overdose:

- Extremely pale face and/or feels clammy to the touch
- Body goes limp
- Fingernails or lips have a purple or blue color
- Vomiting or making gurgling noises
- Unable to be awakened or unable to speak
- Breathing or heartbeat slows or stops

Educating the family/caregivers about the signs of an opioid overdose may help detect problems before they lead to a serious complication. Patients and family/caregivers should also learn to recognize the danger signs of respiratory depression (see Recommendation 7.2) and know how to offer help and summon medical help immediately. Counseling about administration of naloxone for suspected overdose should be provided in those cases where naloxone is co-prescribed. Naloxone can be prescribed by a healthcare provider or by a pharmacist, as per the Utah Department of Health standing order.

Once naloxone is administered, professional emergency care needs to be provided by calling 911. Naloxone wears off in 30-90 minutes, so naloxone administration may need to be repeated. Meanwhile, CPR or mouth-to-mouth resuscitation may also need to be administered, so family/caregivers should receive training in both when naloxone is prescribed. *Warning:* The standard IV dosage of naloxone is 0.4 mg and the intranasal dose is 2-4 mg. Administering an excessive amount of naloxone by repeating doses too frequently or using a high-dose preparation can cause the patient to experience acute opioid withdrawal symptoms which can cause seizures or even be life threatening.

Naloxone may not be effective if opioids are misused in combination with other sedatives or stimulants. It is not effective in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines[9].

See Instructions for Naloxone Administration in the Tools and Resources section. Additional information about naloxone for the public, prescribers, pharmacists, and first responders can be found at **naloxone.utah.gov**.

Chronic Pain Recommendation 7.7: Counsel Patients on Safe Storage, Disposal, and Diversion
Patients should be encouraged to securely store their medications, not share with others, and to dispose of opioids properly when the pain has resolved to prevent non-medical use of the medications.

For patient education materials and resources on safe storage and disposal, visit **www.useonlyasdirected.org**.

[9] Substance Abuse and Mental Health Services Administration. [Naloxone]. (2016, March 03). Retrieved June 28, 2017, from https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone.

Treatment Management (8.1-10.2)

Chronic Pain Recommendation 8. Monitoring Treatment and Dose Adjustments

Chronic Pain Recommendation 8.1: Monitor Opioid Therapy
Once a stable dose has been established, regular monitoring should be conducted at face-to-face visits. During these visits, treatment goals, affect and mood, analgesia, activity and level of function, adverse effects, and aberrant behaviors should be monitored.

These assessments can be remembered as the "5 A's."
5 A's Opioid Therapy Monitoring Tool

1. ***A**ffect:* determine if pain has impacted the patient's mood
2. ***A**nalgesia*: inquire about level of pain (current, recent, trends, etc.)
3. ***A**ctivity*: assess both the patient's function and overall quality of life
4. ***A**dverse events*: determine whether the patient is having medication side effects
5. ***A**berrant behavior*: regularly evaluate for possible substance use disorder related behavior

Also, it is recommended to assess the patient's *airway and sleep apnea* status[10].

Chronic Pain Recommendation 8.2: Evaluate Patient Progress
Continuation or modification of therapy should depend on the prescriber's evaluation of progress towards stated treatment goals.

Prescribers should evaluate benefits and harms of continued opioid therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, prescribers should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids[11].

Chronic Pain Recommendation 8.3: Adjust and Prescribe Medication During Clinic Visit
Medication adjustments, if necessary, should be made and prescriptions provided during a clinic visit.

Face-to-face follow-up visits should occur at least every 2-4 weeks during any period when dosages are being adjusted. More frequent follow-up visits may be advisable when prescribing opioid medication to a patient with a known addiction problem, suspected aberrant behavior, or co-existing psychiatric or medical problems.

Options for medication adjustments include reducing medication or rotating opioid medication. Opioid rotation can be an effective means of reducing opioid dose, reducing adverse side effects or improving efficacy. However, when switching from one opioid to another, extreme caution is required due to incomplete cross-tolerance among various opioids. Refer to opioid rotation guidelines before

[10] Federation of State Medical Boards. [Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain]. 2013 [11]
[11] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016;65(No. 1):[16]

attempting an opioid switch (opioid rotation). When it is documented that the patient is compliant with agreed-upon recommendations, the prescriber may consider adding supplemental immediate-release/short-acting (IR/SA) medications for control of break-through pain exacerbation to facilitate increases in activity.

In general, if the patient's underlying medical condition is chronic and unchanging and if opioid-associated problems (hyperalgesia, substantial tolerance, important adverse effects) have not developed, it is recommended that the effective dose achieved through titration not be lowered once the patient has reached a plateau of adequate pain relief and functional level[12].

Chronic Pain Recommendation 9. Multi-Disciplinary Approach

Chronic Pain Recommendation 9.1: Obtain a Second Opinion or Consultation
Prescribers should obtain a consultation for a patient with complex pain conditions or serious comorbidities.

Reasons to refer patients include:

- The prescriber has reached a limit of what he or she feels comfortable prescribing.
- The treatment needs a multi-disciplinary approach.
- The pain has progressed to a complex level.
- Significant risk factors for substance use disorder are identified.
- There is a need to re-evaluate the patient's diagnosis and/or confirm the continued diagnosis.

A multidisciplinary approach for chronic pain may result in a better outcome compared to medical management alone. The results generally indicate a reduction in pain, better functional restoration, reduced healthcare costs, higher return-to-work rates, and reduced disability costs.

Patients with serious comorbidities may benefit from a Palliative Care consultation if the goal is to improve a person's quality of life while living with chronic or serious illness. These patients usually have exhausted other traditional therapies for their illnesses (congestive heart failure, COPD, advanced cancer) or live with a high symptom burden during treatment of their illness. They are not hospice eligible, because they live longer than a traditional hospice patient or may have aggressive medical goals. Patients that receive palliative care may have less frequent hospitalizations, improved quality of life, and improved physical function[13].

Chronic Pain Recommendation 9.2: Refer to a Substance Use Disorder Specialist for Treatment
Patients at high risk for Substance Use Disorder (SUD) or those exhibiting behaviors of abuse, diversion, or addiction should be referred to a SUD specialist for treatment.

[12] Department of Veterans Affairs, Department of Defense. [VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain]. 2003.
[13] April Krutka, Palliative Care Medical Director, McKay Dee Hospital.

Find Substance Abuse Agencies by county at **dsamh.utah.gov/substance-use-disorders/**. Also, see the Tools and Resources section for a list of Opioid Use Disorder Providers.

Chronic Pain Recommendation 9.3: Offer Medication-Assisted Treatment
Prescribers should offer or arrange evidence-based treatment for a patient with opioid use disorder, which usually includes medication-assisted treatment with buprenorphine, naltrexone, or methadone in combination with behavioral therapies.

The prescriber may consider opioid medication for pain when monitoring is performed during the titration and maintenance phase and the patient understands and consents to the risks, even if the patient has a self-reported or documented previous problem with opioids. Opioid treatment in this case requires more structured ongoing assessment for loss of control and nonadherence. Co-management with or a referral to an addiction medicine specialist is recommended. The specialist is required to have a special registration to provide medication-assisted treatment; otherwise, there is a provision in the Utah Controlled Substance Act in which the provider may apply to receive a waiver of the special registration requirements to treat with buprenorphine. This can be done through the Substance Abuse Mental Health Services Administration Buprenorphine Waiver Management at **www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management**.

Chronic Pain Recommendation 9.4: Refer to Mental Health Services
Patients with co-existing psychiatric disorders should receive ongoing mental health support and treatment while being treated for chronic pain.

Unless the prescriber treating the patient is qualified to provide the appropriate care and evaluation of the coexisting psychiatric disorder, consultation should be obtained to assist in formulating the treatment plan and establishing a plan for coordinated care of both the chronic pain and psychiatric conditions.

Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, use validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the PHQ-4 to assess for anxiety, post-traumatic stress disorder, and/or depression (*205*)[14].

Opioid therapy should not be initiated during acute psychiatric instability or uncontrolled suicide risk, and prescribers should consult a behavioral health specialist for any patient with a history of suicide attempt or psychiatric disorder. In addition, patients with anxiety disorders and other mental health conditions are more likely to receive benzodiazepines, which can exacerbate opioid-induced respiratory depression and increase the risk for overdose. For treatment of chronic pain in patients with depression, prescribers should strongly consider using tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects[15].

[14] Centers for Disease Control, 2016.
[15] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016;65(No. 1):[27].

Chronic Pain Recommendation 10. Discontinuing Opioid Treatment

Chronic Pain Recommendation 10.1: Discontinue Treatment
Opioid treatment should be discontinued when pain problems have been resolved, treatment goals are not being met, adverse effects outweigh benefits, or dangerous or illegal behaviors are demonstrated.

Dangerous or illegal behaviors may include frequent requests for refills prior to the expected use date, positive urine drug screens for non-prescribed medications, negative urine drug screens for opiates that have been prescribed and the patient states they are taking, and suspicion of diverting medications to others.

The decision to discontinue opioid treatment should ideally be made jointly with the patient and the family/caregivers when appropriate (Federation of State Medical Boards, 2004). This decision requires careful consideration of the treatment outcomes and the need to provide ongoing monitoring.

When the patient is discharged, the prescriber is obliged to offer continued monitoring for 30 days post-discharge. Once a provider-patient relationship is established, the prescriber owes a continuing duty to provide care until that relationship is appropriately terminated. Prescribers should adhere to the standard of care for their specific discipline when dismissing a patient. The failure to do so may constitute neglect or abandonment.

Chronic Pain Recommendation 10.2: Safely Taper and Refer to Treatment
When a patient chooses to stop treatment or has been discharged for treatment plan violations, offer assistance to safely taper medications or obtain appropriate treatment.

When tapering a patient from opioid treatment, the rate of taper will depend on their medical, social, and mental health factors. Medicine should be dispensed in small increments, no more than a weekly supply. Strategies for Tapering and Weaning can be found in the Tools and Resources section. For prescribers who are not familiar with opioid tapering within the context of pain care (i.e., no opioid use disorder co-morbidity), consultation with a pain medicine specialist is recommended. If opioid use disorder is suspected, consultation with a SUD specialist is recommended.

When patients receiving both benzodiazepines and opioids require tapering to reduce risk for fatal respiratory depression, it might be safer and more practical to taper opioids first (see Recommendation 7). The reason for this is because there is a greater risk of benzodiazepine withdrawal relative to opioid withdrawal and tapering opioids can be associated with anxiety. Prescribers should taper benzodiazepines gradually, because if discontinued abruptly this may cause withdrawal with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death. A commonly used benzodiazepine tapering schedule that has been used safely and with moderate success is a reduction of the benzodiazepine dose by 25% every 1–2 weeks[16].

[16] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016;65(No. 1):[32].

Chronic Pain Recommendation 11. Methadone

Chronic Pain Recommendation 11.1: Avoid Methadone Unless Trained
Methadone should not be used for pain unless the prescriber has extensive training or experience in its use and when the benefits outweigh the known risks.

Methadone has highly complex and variable pharmacokinetics and pharmacodynamics, making it unsuitable as a preferred (1st or 2nd line) extending-release/long-acting (ER/LA) opioid analgesic for the management of chronic pain when around-the-clock opioids are indicated. Its use for this indication has been associated with a disproportionately high incidence of prescription opioid-related deaths.

Methadone is one option for maintenance therapy for patients who are addicted to opioids, who have been transitioned from their other opioid medications, and who are under a frequent urine drug screening plan. The DEA requires special registration as a Narcotic Treatment Program (NTP) for prescribers to use methadone for this purpose. Buprenorphine is another option for long-term therapy of opioid use disorder.

An ECG screening should be performed on patients who will be receiving methadone.
Caution: Anti-depressants may prolong the QT interval and increase the risk of cardiac death when taken with methadone.

Acronyms

Acronym	Definition
CSD	Utah Controlled Substance Database
CDC	Centers for Disease Control and Prevention
CNS	Central Nervous System
CPR	Cardiopulmonary Resuscitation
DOPL	Utah Division of Occupational and Professional Licensing
ER/LA [opioid]	Extended-release/Long-acting Opioid
HIPAA	Health Insurance Portability and Accountability Act
IM or SC [injections]	Intramuscular or Subcutaneous Injections
IR/SA [opioid]	Immediate-release/Short-acting Opioid
MME	Morphine Milligrams Equivalents
NSAID	Non-steroidal Anti-inflammatory Drug
PTSD	Post-traumatic Stress Disorder
SNRI [antidepressant]	Serotonin and Norepinephrine Reuptake Inhibitors
SUD	Substance Use Disorder

Glossary

Term	Definition
Aberrant drug-related behavior	A behavior associated with drug abuse, addiction, and diversion.
Abuse	Maladaptive pattern of drug use that results in harm or places the individual at risk of harm. Often with the intent of seeking a psychotropic/euphoric effect.
Acute pain	An episode of self-limiting pain lasting hours to days to weeks and has a clear pathological explanation.
Addiction	A chronic, relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences.
Breakthrough pain	Transient, severe pain occurring against a background of stable, persistent, adequately controlled pain.
Chronic pain	An episode of pain lasting more than three months, persists due to ongoing disease or injury, and persists in the absence of ongoing tissue damage.
Chronic non-cancer pain	Chronic pain that is not associated with active cancer or occurs at the end of life.
Diversion	The intentional transfer of a controlled substance from authorized to unauthorized possession or channels of distribution.
Hyperalgesia	Increased or heightened sensation to pain or pain stimulation.
Immunoassays	An immunological laboratory test usually using antigen-antibody reactions to determine the presence of specific molecules, including drugs.
Misuse	Use of a drug in ways other than prescribed by a health professional. Misuse usually does not include use for euphoric or psychotropic effects—that would be classified as "abuse."
Naloxone	An opioid antagonist agent used to block or reverse respiratory depressant effects of an opioid.

Pathophysiology	The disordered (abnormal) physiological processes associated with disease or injury.
Physical dependence	A state of adaptation manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.
Pseudo addiction	The development of abuse-like behaviors due to unrelieved pain, which is resolved when pain is effectively treated.
Trial period	A period of time during which the effectiveness of using opioids is tested to see if goals of functionality and decreased pain are met.
Tolerance	A state of adaptation in which exposure to a drug induces changes that result in a diminished response of one or more opioid effects over time.

Tools and Resources

Comprehensive Patient Evaluation

Pain Assessment and Documentation Tool (PADT™)

Brief Pain Inventory (BPI©)

Treatment Plan Agreement (sample)

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R©)

Current Opioid Misuse Measure (COMM©)

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Opioid Use Disorder Providers

CDC Clinical Pocket Guide Tapering

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www.health.utah.gov/prescription
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For additional tools and information visit:
prc.coh.org/culture.asp
www.PainEdu.org

Current Opioid Misuse Measure (COMM)®

The Current Opioid Misuse Measure (COMM)® is a brief patient self-assessment to monitor chronic pain patients on opioid therapy. The COMM was developed with guidance from a group of pain and addiction experts and input from pain management clinicians in the field. Experts and providers identified six key issues to determine if patients already on long-term opioid treatment are exhibiting aberrant medication-related behaviors:

- *Signs & Symptoms of Intoxication*
- *Emotional Volatility*
- *Evidence of Poor Response to Medications*
- *Addiction*
- *Healthcare Use Patterns*
- *Problematic Medication Behavior*

The COMM will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP®) is intended to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future. Since the COMM examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment. The COMM is:

- A quick and easy to administer patient-self assessment
- 17 items
- Simple to score
- Completed in less than 10 minutes
- Validated with a group of approximately 500 chronic pain patients on opioid therapy
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The COMM is for clinician use only. The tool is not meant for commercial distribution.
- The COMM is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with COMM scores to decide if and when modifications to particular patient's treatment plan is needed.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

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PainEDU
Improving Pain Treatment Through Education

Current Opioid Misuse Measure (COMM)®

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

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PainEDU
Improving Pain Treatment Through Education

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

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Scoring Instructions for the Current Opioid Misuse Measure (COMM)®

To score the COMM, simply add the rating of all the questions. A score of 9 or higher is considered a positive

Sum of Questions	COMM Indication
> or = 9	**+**
< 9	**-**

As for any scale, the results depend on what cutoff score is chosen. A score that is sensitive in detecting patients who are abusing or misusing their opioid medication will necessarily include a number of patients that are not really abusing or misusing their medication. The COMM was intended to over-identify misuse, rather than to mislabel someone as responsible when they are not. This is why a low cut-off score was accepted. We believe that it is more important to identify patients who have only a possibility of misusing their medications than to fail to identify those who are actually abusing their medication. Thus, it is possible that the COMM will result in false positives – patients identified as misusing their medication when they were not.

The table below presents several statistics that describe how effective the COMM is at different cutoff values. These values suggest that the COMM is a sensitive test. This confirms that the COMM is better at identifying who is misusing their medication than identifying who is not misusing. Clinically, a score of 9 or higher will identify 77% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 9 is .95, which means that most people who have a negative COMM are likely not misusing their medication. Finally, the Positive likelihood ratio suggests that a positive COMM score (at a cutoff of 9) is over 2 times (2.26 times) as likely to come from someone who is actually misusing their medication (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 9 will ensure that the provider is least likely to miss someone who is really misusing their prescription opioids. However, one should remember that a low COMM score suggests the patient is really at low-risk, while a high COMM score will contain a larger percentage of false positives (about 34%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

COMM Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 9 or above	.77	.66	.66	.95	2.26	.35

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PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Patient Stamp Here

Patient Name: _____ Record #: _____

Assessment Date: _____

Current Analgesic Regimen

Drug name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

***The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician.* Ask the patient the questions below, except as noted.**

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.) _____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?
❑ Yes ❑ No

5. Query to clinician: Is the patient's pain relief clinically significant?
❑ Yes ❑ No ❑ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	❑	❑	❑
2. Family relationships	❑	❑	❑
3. Social relationships	❑	❑	❑
4. Mood	❑	❑	❑
5. Sleep patterns	❑	❑	❑
6. Overall functioning	❑	❑	❑

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

(Continued on reverse side)

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PROGRESS NOTE
Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever(s)? ❑ Yes ❑ No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	❑	❑	❑	❑
b. Vomiting	❑	❑	❑	❑
c. Constipation	❑	❑	❑	❑
d. Itching	❑	❑	❑	❑
e. Mental cloudiness	❑	❑	❑	❑
f. Sweating	❑	❑	❑	❑
g. Fatigue	❑	❑	❑	❑
h. Drowsiness	❑	❑	❑	❑
i. Other _____		❑	❑	❑
j. Other _____		❑	❑	❑

2. Patient's overall severity of side effects?
❑ None ❑ Mild ❑ Moderate ❑ Severe

Potential Aberrant Drug-Related Behavior

This section must be completed by the physician.

*Please **check** any of the following items that you discovered during your interactions with the patient.* Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ❑ Purposeful over-sedation
- ❑ Negative mood change
- ❑ Appears intoxicated
- ❑ Increasingly unkempt or impaired
- ❑ Involvement in car or other accident
- ❑ Requests frequent early renewals
- ❑ Increased dose without authorization
- ❑ Reports lost or stolen prescriptions
- ❑ Attempts to obtain prescriptions from other doctors
- ❑ Changes route of administration
- ❑ Uses pain medication in response to situational stressor
- ❑ Insists on certain medications by name
- ❑ Contact with street drug culture
- ❑ Abusing alcohol or illicit drugs
- ❑ Hoarding (ie, stockpiling) of medication
- ❑ Arrested by police
- ❑ Victim of abuse

Other: _____

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ❑ Yes ❑ No ❑ Unsure

Comments: _____

Specific Analgesic Plan:

- ❑ Continue present regimen
- ❑ Adjust dose of present analgesic
- ❑ Switch analgesics
- ❑ Add/Adjust concomitant therapy
- ❑ Discontinue/taper off opioid therapy

Comments: _____

Date: _____ Physician's signature: _____

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JANSSEN PHARMACEUTICA PRODUCTS, L.P.

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #: _____

Brief Pain Inventory (Short Form)

Date: ____ / ____ / ____ Time: _____

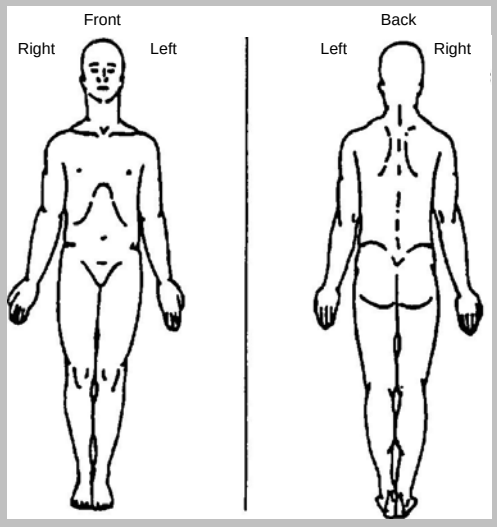
Name: _____ _____ _____

Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #: _____

Date: ____/ ____ / ____ Time: _____

Name: _____ _____ _____

Last First Middle Initial

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

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HEALTH CLINICS OF UTAH

CONTROLLED SUBSTANCE AGREEMENT USING PRESCRIPTION OPIOIDS AND OTHER CONTROLLED SUBSTANCES

PATIENT NAME: _____

PRESCRIBER NAME: _____

THE PURPOSE OF THIS AGREEMENT IS TO STRUCTURE OUR PLAN TO WORK TOGETHER TO TREAT YOUR CHRONIC PAIN AND OTHER CONDITIONS REQUIRING CONTROLLED SUBSTANCES. THIS WILL PROTECT YOUR ACCESS TO OPIOID PAIN MEDICATIONS AND OUR ABILITY TO PRESCRIBE THEM TO YOU.

I (patient) understand the following (initial each):

____ Opioids/controlled substances have been prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including return to work. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.

____ Goal for improved function: See Initial Evaluation and subsequent follow-up visits.

____ Opioids/controlled substances are being prescribed to make my pain/symptoms tolerable but may not cause it to disappear entirely. If this goal is not reached, my medical provider may end the trial.

Goal for reduction of pain/symptoms: See Initial Evaluation and subsequent follow-up visits.

____ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to myself or others.

____ Using opioids to treat chronic pain will result in the development of physical dependence and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, depressed mood, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

____ There is a small but significant risk that opioid psychological dependence (addiction) can occur. If it appears that I may be developing addiction, my medical provider may determine to end the trial.

____ The patient education as discussed above applies to all controlled substances, though usage and adverse effects (including dependence and addiction) of medications vary. Your medical provider will address other controlled substances if they are a part of your treatment program.

I agree to the following (initial each):

____ I agree to take medications as prescribed. Using medications at a faster rate or increased dose other than prescribed may result in death.

____ I agree to have regular office visits as decided by my medical provider. I understand that this agreement will be null and void if more than 15 days elapse past my anticipated, regular appointment time.

____ I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.

____ I agree not to share, sell, or in any way provide my medication to any other person.

____ I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my medical provider may check the Utah Controlled Substance Database at any time to check my compliance.

____ I agree not to seek or obtain **ANY** mood-modifying medication, including pain relievers or tranquilizers from **ANY** other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this agreement. I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

____ I agree to refrain from the use of **ALL** other mood-modifying drugs (prescription and illicit), including alcohol and marijuana. My medical provider may prescribe other controlled substances as part of my treatment plan.

____ I agree to submit to random urine or blood for drug testing at my prescriber's request. I understand that it is my responsibility to pay for drug screening if self pay or it is not covered by insurance. I agree to have random pill counts at my prescriber's request. I must have access to a telephone and able to be reached by telephone within 24 hours. Drug testing and pill counts verify compliance with my treatment plan. If I cannot produce urine or blood at the time requested, this will be grounds for termination of pain management services. I agree to being seen by an addiction specialist if requested.

____ I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time. In consideration of my treatment goals, I agree to help myself by following better health habits, including exercise, smoking cessation, and weight control.

____ I agree to attend and participate fully in a mental health evaluation and/or treatment for mental health disorders (i.e. depression, anxiety, etc) as may be recommended by the prescriber at any time

____ I understand that this contract also applies to any and all controlled substances that are part of my total treatment program, not just limited to pain management.

I understand that ANY deviation from the above agreement will be grounds for termination of controlled substance prescribing services at any time.

Medications Covered By This Agreement:

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy	**Address**
Patient Signature	**Date**
Prescriber Signature	**Date**

Violation:_____

_____

_____

_____

_____

Date of Violation:_____**; Letter of Termination? YES/NO**

Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)

The Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R) is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. This is an updated and revised version of SOAPP V.1 released in 2003.

Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP®-R is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. SOAPP®-R is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Validated with 500 chronic pain patients
- Simple to score
- 24 items
- <10 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP®-R is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP®-R is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP®-R scores to decide on a particular patient's treatment.
- The SOAPP®-R is **NOT** intended for all patients. The SOAPP®-R should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

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▪ Phone (617) 332-6028 ▪ Fax (617) 332-1820 ▪ www.inflexxion.com
The Screener and Opioid Assessment for Patients with Pain was developed with a grant from the National Institutes of Health (#2R44DA015617-02)

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

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Scoring Instructions for the SOAPP®-R®

All 24 questions contained in the SOAPP®-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP, add the ratings of all the questions. A score of 18 or higher is considered positive.

Sum of Questions	SOAPP®-R Indication
> or = 18	**+**
< 18	**-**

What does the Cutoff Score Mean?

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP®-R generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP®-R is at different cutoff values. These values suggest that the SOAPP®-R is a sensitive test. This confirms that the SOAPP®-R is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP®-R are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP®-R score (at a cutoff of 18) is nearly 4 times (3.80 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 18 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP®-R score suggests the patient is very likely at low-risk, while a high SOAPP®-R score will contain a larger percentage of false positives (about 30%); at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

SOAPP®-R Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 17 or above	.83	.65	.56	.88	2.38	.26
Score 18 or above	.81	.68	.57	.87	3.80	.29
Score 19 or above	.77	.75	.62	.86	3.03	.31

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▪ Phone (617) 332-6028 ▪ Fax (617) 332-1820 ▪ www.inflexxion.com
The Screener and Opioid Assessment for Patients with Pain was developed with a grant from the National Institutes of Health (#2R44DA015617-02)

How does the SOAPP®-R help determine appropriate treatment?

The SOAPP®-R should only be one step in the assessment process to determine which patients are high-risk for opioid misuse. The following discussion examines the assessment and treatment options for chronic pain patients who are at risk (high risk or medium risk) and those who are likely not at risk.

Who is at a high risk for opioid misuse? (SOAPP®-R score = 22 or greater*)

Patients in this category are judged to be at a high risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at a higher risk for opioid misuse. Some examples of these behaviors or beliefs include a current or recent history of alcohol or drug abuse, being discharged from another physician' care because of his/her behavior, and regular noncompliance with physicians' orders. These patients may have misused other prescription medications in the past. It is a good idea to review the SOAPP®-R questions with the patient, especially those items the patient endorsed. This will help flesh out the clinical picture, so the provider can be in the best position to design an effective, workable treatment plan.

Careful and thoughtful planning will be necessary for patients in this category. Some patients in this category are probably best suited for other therapies or need to exhaust other interventions prior to entering a treatment plan that includes chronic opioid therapy. Others may need to have psychological or psychiatric treatment prior to or concomitant with any treatment involving opioids. Patients in this category who receive opioid therapy should be required to follow a strict protocol, such as regular urine drug screens, opioid compliance checklists, and counseling.

Specific treatment considerations for patients in this high-risk category:

- Past medical records should be obtained and contact with previous and current providers should be maintained.
- Patients should also be told that they would be expected to initially give a urine sample for a toxicology screen during every clinic visit. They should also initially be given medication for limited periods of time (e.g., every 2-weeks).
- Ideally, family members should be interviewed and involvement with an addiction medicine specialist and/or mental health professional should be sought.
- Less abusable formulations should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation, tamper-resistant medications).
- Early signs of aberrant behavior and a violation of the opioid agreement should result in a change in treatment plan. Depending on the degree of violation, one might consider more restricted monitoring, or, if resources are limited, referring the patient to a program where opioids can be prescribed under stricter conditions. If violations or aberrant behaviors persist, it may be necessary to discontinue opioid therapy.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

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Who is at a moderate risk for opioid misuse? (SOAPP®-R score = 10 to 21*)

Patients in this category are judged to be at a medium or moderate risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at some risk for misuse. Some examples of these behaviors or beliefs are family history of drug abuse, history of psychological issues such as depression or anxiety, a strong belief that medications are the only treatments that will reduce pain and a history of noncompliance with other prescription medications. It is a good idea to review the SOAPP®-R items the patient endorsed with the patient present.

Some of these patients are probably best treated by concomitant psychological interventions in which they can learn to increase their pain-coping skills, decrease depression and anxiety, and have more frequent monitoring of their compliance. They may need to be closely monitored until proven reliable by not running out of their medications early and having appropriate urine drug screens.

Additional treatment considerations for patients in this category:

- Periodic urine screens are recommended.
- After a period in which no signs of aberrant behavior are observed, less frequent clinic visits may be indicated. If there are any violations of the opioid agreement, then regular urine screens and frequent clinic visits would be recommended.
- After two or more violations of the opioid agreement, an assessment by an addiction medicine specialist and/or mental health professional should be mandated.
- After repeat violations referral to a substance abuse program would be recommended. A recurrent history of violations would also be grounds for tapering and discontinuing opioid therapy

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

Who is at a low risk for opioid misuse? (SOAPP®-R score < 9*)

Patients in this category are judged to be at a low risk for opioid misuse. These patients have likely tried and been compliant with many other types of therapies. They should be able to handle their medication safely with minimal monitoring. They are apt to be responsible in their use of alcohol, not smoke cigarettes, and have no history of previous difficulties with alcohol, prescription drugs, or illegal substances. This patient probably reports few symptoms of affective distress, such as depression or anxiety.

As noted previously, the SOAPP®-R is not a lie detector. The provider should be alert to inconsistencies in the patient report or a collateral report. Any sense that the patient's story "doesn't add up" should lead the provider to take a more cautious approach until experience suggests that the person is reliable.

Patients in this category would be likely to have no violations of the opioid treatment agreement. These patients are least likely to develop a substance abuse disorder. Additionally, they may not require special monitoring or concomitant psychological treatment.

Additional treatment considerations for patients in this category:

- Review of SOAPP®-R questions is not necessary, unless the provider is aware of inconsistencies or other anomaly in patient history/report.

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- Frequent urine screens are not indicated.
- Less worry is needed about the type of opioid to be prescribed and the frequency of clinic visits.
- Efficacy of opioid therapy should be re-assessed every six months, and urine toxicology screens and update of the opioid therapy agreement would be recommended annually.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

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COMPREHENSIVE PATIENT EVALUATION

A comprehensive history and physical examination are critical for both the patient's physical health and completion of the patient's personal history, including social, medical, psychiatric, psychological, and substance abuse.

The social history should include:

- Employment status,
- social network,
- marital history, and any
- history of legal problems related to controlled substances.

When gathering a past medical history,

- Assess the pain, emphasizing functional deficits prior to treatment
- Determine the cause of the pain and the severity of the pain
- Assess effects of the pain on the patient's life and function, including the functional status of the patient during work, home and family activities, and recreational activities
- Patient's perceived quality of life using a method/instrument that can be used later to evaluate treatment effectiveness
- Assess for the presence of medical conditions that might complicate the treatment of the pain, including medication allergy, cardiac or respiratory disease, liver disease, renal disease, and sleep apnea or the risk factors for sleep apnea

When gathering a mental health and substance use history,

- Obtain history of substance use, addiction, or dependence
- Assess the use of other substances, including alcohol, and illicit drug use such as marijuana, cocaine, and methamphetamines
- Identify use of other medications that might interact with medications used to treat the pain. Particular attention should be given to benzodiazepines and other sedative medications
- Identify psychiatric conditions that may affect pain or treatment of pain.
- Ask patient about other depressants they are taking, including benzodiazepines and diphenhydramine which is contained in the over-the-counter products, Benadryl™ and Sominex™ as they are risks for opioid overdose
- Assess and evaluate prior approaches to the patient's pain management
- Assess risk of sleep apnea

When gathering pain specific information, it can be helpful to use the mnemonic OPQRST.

O*nset* – When did pain/does pain begin?
P*ain* – Gets better with_____ or gets worse with_____.
Q*uality* – Does it cause burning/achiness/other symptoms?
R*adiation* – Where does pain start and where does it spread?
S*everity* – Use a validated pain rating scale for self-reporting patients. For those unable to self-report due to dementia, you may use PainAD found in the resource section.

T*emporal Course*

– Is there a constant or episodic pattern?
– When is the pain most severe?
– Is there breakthrough pain? What is the frequency, severity, and duration of the breakthrough pain? Is it incident pain caused by specific activity or action? Spontaneous pain with no identifiable cause? End-of-dose failure where the pain returns before next dose of regularly scheduled medicine takes effect?

– It may be helpful for an able patient or caregiver to use a 24-hour pain diary to help identify many factors and effects of interventions.

Following the comprehensive history, the prescriber needs to complete a physical examination to

- Assess the pain, emphasizing functional deficits prior to treatment;
- Determine the cause of the pain as specifically as possible and institute diagnosis-specific therapy immediately;
- Assess effects of the pain on the patient's life and function, including the
  - Functional status of the patient during work, home and family activities, and recreational activities
  - Patient's perceived quality of life and the
  - Severity of the pain; and finally,
- Assess for the presence of medical conditions that might complicate the treatment of the pain, including medication allergy, cardiac or respiratory disease, liver disease, renal disease, and sleep apnea or the risk factors for sleep apnea.

NAME: _____ DATE: _____

DRUG USE QUESTIONNAIRE (DAST – 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.	**Circle Your Response**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you had "blackouts" or "flashbacks" as a result or drug use?	Yes	No
5. Do you every feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

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GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-4

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

<u>Scoring</u>

PHQ-4 total score ranges from 0 to 12, with categories of psychological distress being:

- None 0-2
- Mild 3-5
- Moderate 6-8
- Severe 9-12

Anxiety subscale = sum of items 1 and 2 (score range, 0 to 6)

Depression subscale = sum of items 3 and 4 (score range, 0 to 6)

On each subscale, a score of 3 or greater is considered positive for screening purposes

The PHQ scales were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, and Kurt Kroenke and colleagues. The PHQ scales are free to use. For research information, contact Dr. Kroenke at kkroenke@regenstrief.org

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

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A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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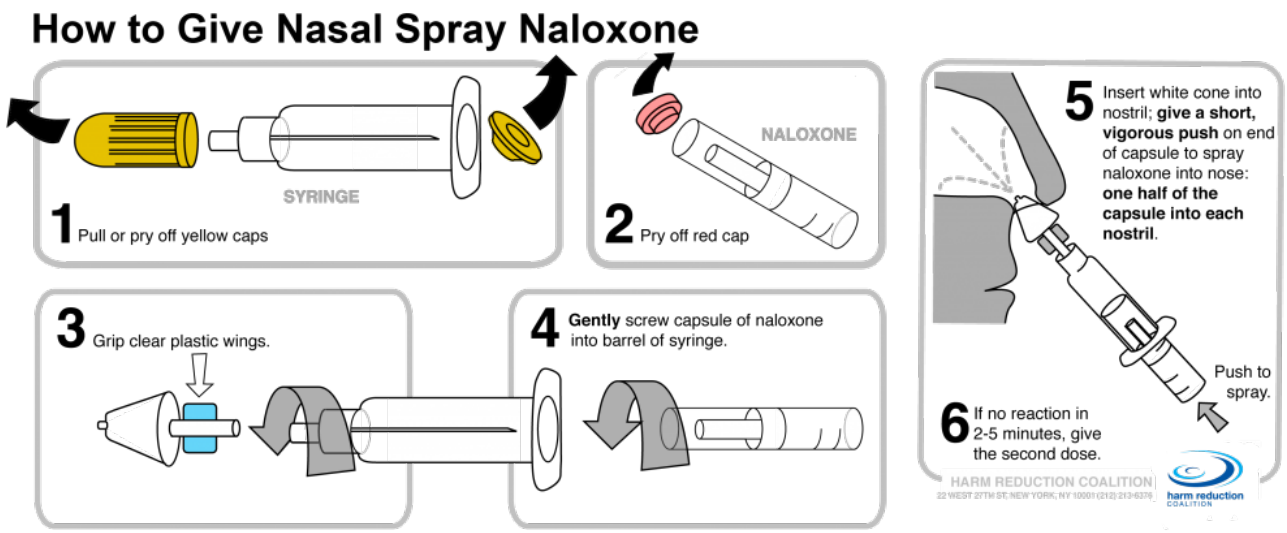
A2662B 10-04-2005

Administer Naloxone

harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/administer-naloxone/

Overdose Response

Nasal Naloxone:



1. Do rescue breathing for a few quick breaths if the person is not breathing.
2. Affix the nasal atomizer (applicator) to the needleless syringe and then assemble the glass cartridge of naloxone (see diagram).
3. Tilt the head back and spray half of the naloxone up one side of the nose (1cc) and half up the other side of the nose (1cc).
4. If there is no breathing or breathing continues to be shallow, continue to perform rescue breathing for them while waiting for the naloxone to take effect.
5. If there is no change in 3-5 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else is wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (can happen with Fentanyl, for example).

Nasal Naloxone – *Photo: N.O.M.A.D (Not One More Anonymous Death)*

Injectable Naloxone:

Injectable naloxone comes packaged in several different forms- a multi dose 10 mL vial and single dose 1mL flip-top vials with a pop off top. With all formulations of naloxone, it is important to check the expiration date and make sure to keep it from light if it is not stored in a box. If someone has an injectable formulation of naloxone, all of the steps in recognizing and responding to an overdose are the same except how to give the naloxone. To use injectable naloxone:

1. Do rescue breathing for a few quick breaths if the person is not breathing.
2. Use a long needle: 1 – 1 ½ inch (called an IM or intramuscular needle)- needle exchange programs and pharmacies have these needles.
3. Pop off the orange top vial
4. Draw up 1cc of naloxone into the syringe 1cc=1mL=100u.
5. Inject into a muscle – thighs, upper, outer quadrant of the butt, or shoulder are best.
6. Inject straight in to make sure to hit the muscle.
7. If there isn't a big needle, a smaller needle is OK and inject under the skin, but if possible it is better to inject into a muscle.
8. After injection, continue rescue breathing 2-3 minutes.
9. If there is no change in 2-3 minutes, administer another dose of naloxone and continue to breathe for them. If the second dose of naloxone does not revive them, something else may be wrong—either it has been too long and the heart has already stopped, there are no opioids in their system, or the opioids are unusually strong and require more naloxone (can happen with Fentanyl, for example).

Once naloxone has been delivered and if the person is not breathing, continued rescue breathing is important until help arrives.

Naloxone only lasts between 30 – 90 minutes , while the effects of the opioids may last much longer. It is possible that after the naloxone wears off the overdose could recur. It is very important that someone stay with the person and wait out the risk period just in case another dose of naloxone is necessary. Also, naloxone can cause uncomfortable withdrawal feelings since it blocks the action of opioids in the brain. Sometimes people want to use again immediately to stop the withdrawal feelings. This could result in another overdose. Try to support the person during this time period and encourage him or her not to use for a couple of hours.

IMPORTANT!

If a victim is not responsive to stimulation, not breathing, and has no pulse after receiving naloxone and rescue breathing, then the victim needs cardiopulmonary resuscitation (CPR) via a trained bystander and the emergency medical system. ***Call 911!***

Emergency Response for Opioid Overdose

harm reduction COALITION

Try to wake the person up

- Shake them and shout.
- If no response, grind your knuckles into their breast bone for 5 to 10 seconds.

Call 911

If you report an overdose, New York State law protects you and the overdosed person from being charged with drug possession, even if drugs were shared.

Administer nasal naloxone

- Assemble nasal naloxone.
- Spray half up each nostril.
- Repeat after 2 to 5 minutes if still not conscious.

Check for breathing

Give CPR if you have been trained, or do rescue breathing:

- Tilt the head back, open the mouth, and pinch the nose.
- Start with 2 breaths into the mouth. Then 1 breath every 5 seconds.
- Continue until help arrives.

Stay with the person

- Naloxone wears off in 30 to 90 minutes.
- When the person wakes up, explain what happened.
- If you need to leave, turn the person on his or her side to prevent choking.

Next Page: Aftercare

OPIOID TREATMENT PROVIDERS BY COUNTY LOCATIONS – OCT 2017

*** Clinics That Have an Emergency Radio**

COUNTY	NAME & ADDRESS	PHONE	DOSING HOURS	CONTACT INFORMATION	OTHER
Davis	Bountiful Treatment Center 146 W 300 S, Suite 100 Bountiful, UT 84010	801- 292-2318 Fax: 801-292-2578	M-F 5:00 AM-11:00AM; S 7:00 AM-10 AM	Program Director: Amber Dickamore bountifulmetro@cmglp.com	www.methadonetreatment.com cell 801-643-6681
	Discovery House 523 W Heritage Park Blvd Layton, UT 84041	801-525-9998 Fax: 801-525-6984	M-F 5:30 -11:00 AM S 7:00 AM -9:00 AM Closed Sundays/Open Holidays	Regional Director Steve Havertz Steve.Havertz@ctcprograms.com	Cell 801-309-6558
Salt Lake	***De Novo** 339 East 3900 South #155 Salt Lake City, Utah 84107	801-263-1056 Fax: 801-261-3701	M-F 5:00-11:00 AM Sat 6:00-8:00 AM Sun & holidays By Appointment	Program Director Jerry Costley jcostley@sprynet.com	Cell 801-347-0370 www.denovoservices.org
	***Discovery House** 5983 S Redwood Road Taylorsville, UT 84123	801-293-9999 Fax: 293-3310	M-F 5:30-11 AM Sat 7:30-10:00 AM Closed Sundays/Open Holidays	Program Director: Dan Hymas Daniel.Hymas@ctcprograms.com	Cell 208-313-7333
	Discovery House 449 E 2100 S Salt Lake City, UT 84115	801-596-2111 Fax: 801-359-3878	M-F 5:30-11 AM Sat 7:30-10 AM Closed Sundays/Open Holidays	Program Director Mark Morgan, BA, ASUDC mark.morgan@ctcprograms.com	Cell 801-856-2576
	***Metamorphosis Salt Lake City, Inc.** 164 East 5900 South # 101 Salt Lake City, UT 84107	801 261-5790 Fax: 801-261-5794	M-F 5:00-11:00 AM Sat 6-8 AM	Program Director: Debra Drabner, BS, SUDC dldrabner@gmail.com Cell 801-631-4835	Shannon Terwedo, CEO shan1057@hotmail.com Cell: 530-320-9220 www.breakaddiction.org
	***Project Reality, Inc.** 150 E 700 S Salt Lake City, UT 84111	801-364-8080 Fax: 801-364-8098	M-F 6-9:30 AM (until noon by appointment) Sat-Sun-Holidays 7-8:30 AM	Executive Director Linda Moore lmoorewiseman@gmail.com	Cell: (801) 558-8496 http://www.projectreality.net
	*** Tranquility Place** 160 E 800 South # B Salt Lake City, UT 84111	801 924-9240 Fax:801-924-9241	M-F 5:30-11:00AM Sat-Sun-Holidays 7:00-9:00AM	Program Director: Tony Talia'uli Jr. TonyJr@Tranquility-place.com	Cell 801-598-0511 *(24/7)* Open 365 Days/year
Utah	***Discovery House** 714 South State Street Orem, UT 84058	801-426-6565 Fax: 801-426-6464	M-F 5:30-11 AM Sat 7:30-10 AM Closed Sundays/Open Holidays	Regional Director Steve Havertz Steve.Havertz@ctcprograms.com	Cell 801-309-6558
	Project Reality, Inc. 151 South University Ave Ste 1400 Provo, UT 84606	801-851-7118 or 801-364-8080 Fax: 801-851-7137	M-F & holidays 5:50-8:30 AM Sat-Sun 7:00-8:30 AM	Executive Director: Linda Moore Cell: (801) 558-8496 lmoorewiseman@gmail.com	
	True North 234 North Orem Blvd Orem UT 84057	Phone: 801-691-0672 Fax: 801-691-0673	M-F 5:30 -11:00 AM Sat 7:00-9:00 AM Sunday Closed	Program Director: Seanna Williams Cell 801-319-1520 seanna@truenorthutah.com	.
Washington	St. George Metro Treatment Center 620 S. 400 E. #404 St. George, UT 84770	435-656-8918 Fax: 435-656-8917	M-F 5:00 AM-10:30 AM (office open until 1:30 PM) Sat. 7 AM –10 AM	Program Director Stanislav Florian Stanislav.florian@cmglp.com	Cell: 435-218-4536 https://newseason.com
Washington	Brookstone Medical Center 198 North 100 East St. George, Utah 84770	435-628-1111 Fax: 435-652-9999	M-F 6:00 AM-11:00AM Saturday – 7:30AM-10:00AM Closed Sunday	Program Director - Christine Brooks cbrooks@brookstonemedicalcenter.com	Cell: 435-767-8410 www.brookstonemedicalcenter.com
Weber	***Metamorphosis Ogden, Inc.** 2557 Lincoln Ave Ogden, UT 84401	801-622-5272 Fax: 801-622-5256	M-F 5:00-10:30 AM Sat 6:30-8:30 AM	Tyler Anderson, MHA, MBA Cell: (801) 628-2757 Tylera.metaogd@gmail.com	Shannon Terwedo CEO Cell 530-320-9220 www.breakaddiction.org

CSAT Approval: Ivette M. Ruiz
Phone: (240) 276-1511
Alternate SOTA: VaRonica Little

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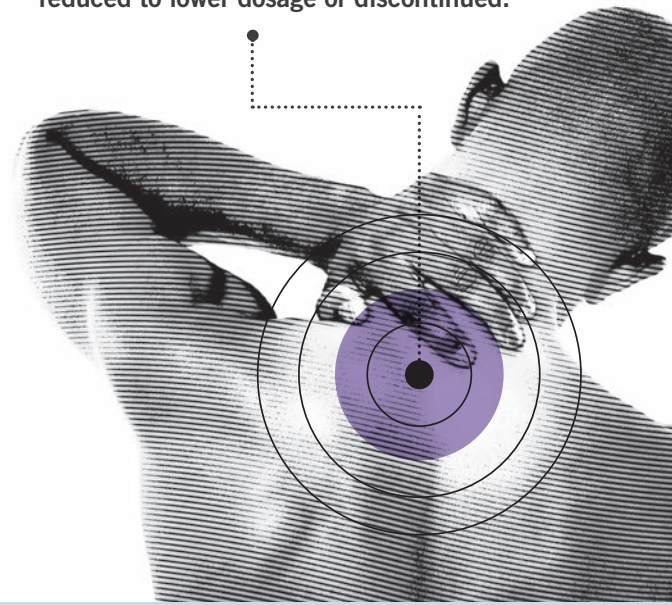
POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN*

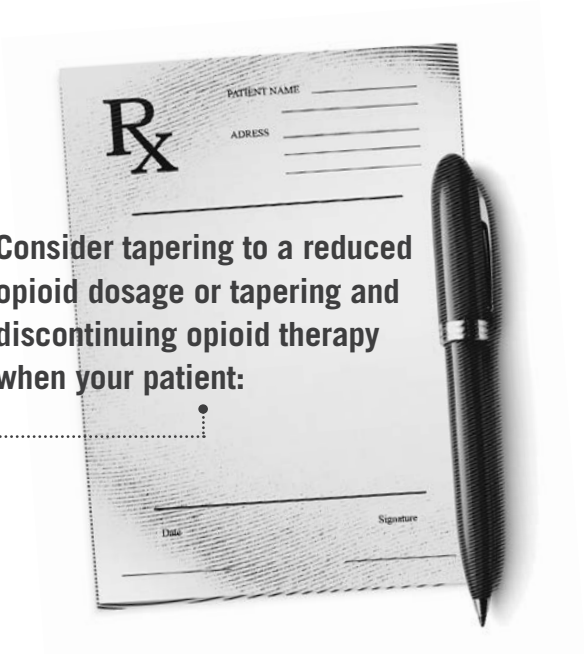
Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

*Recommendations focus on pain lasting longer than 3 months or past the time of normal tissue healing, outside of active cancer treatment, palliative care, and end-of-life care.

WHEN TO TAPER



Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient:

- requests dosage reduction
- does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale)
- is on dosages ≥ 50 MME*/day without benefit or opioids are combined with benzodiazepines
- shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use)
- experiences overdose or other serious adverse event
- shows early warning signs for overdose risk such as confusion, sedation, or slurred speech

*morphine milligram equivalents

HOW TO TAPER

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:

Go Slow

A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.

Consult

Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

Support

Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.

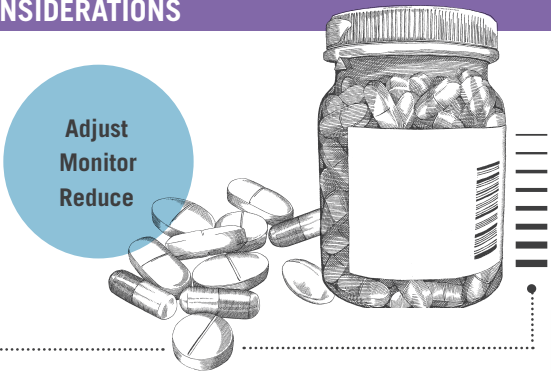
Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

Tell patients "I know you can do this" or "I'll stick by you through this."

CONSIDERATIONS



1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

RESOURCES:

CDC Guideline for Prescribing Opioids for Chronic Pain
www.cdc.gov/drugoverdose/prescribing/guideline.html

Washington State Opioid Taper Plan Calculator
www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain
www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

www.cdc.gov/drugoverdose

Summary of Most Recent Utah Controlled Substances Laws and Rules

Disclaimer: This document is a quick reference to some of the newest laws and rules as of June 2019 that may affect your professional license or practice. This is not a comprehensive legal guide to the topics. Each Controlled Substances Licensee is responsible to be aware and abide by all applicable Utah and Federal regulations.

Prescribing Opioids

Schedule II Prescriptions: 30 Days Max; 3 Rx Max [Utah Code 58-7(f)]
Generally, quantities for one prescription should not exceed a one-month supply for Schedule II drugs.

A practitioner may issue more than one prescription at the same time for the same Schedule II controlled substance, but only under the following conditions:

(a) No more than three prescriptions for the same Schedule II controlled substance may be issued at the same time;

(b) No one prescription may exceed a 30-day supply; and

(c) A second or third prescription shall include the date of issuance and the date for dispensing.

Acute opioid prescription generally not to exceed 7-day supply [Utah Code 58-37-6(7)(f)(iii)]
Utah law states that a prescription for a Schedule II or III opiate for an acute condition shall not be filled to exceed a seven-day supply as directed on the daily dosage rate of prescription. This limitation does not apply when a prescription is 1) issued for a surgery and the prescriber determines more is needed (up to a 30-day supply max); or 2) issued for complex or chronic conditions which are documented in the medical record.

Partial Filling of Schedule II Prescription [Utah Code 58-17b-610.7]
Prescribers or patients may request that a Schedule II prescription be partially filled and then, if more is needed, the patient may pick up the rest of the prescription within the time period allowed for that prescription. The intent is to help keep unused prescriptions out of medicine cabinets.

This works in conjunction with the recently passed federal law Comprehensive Addiction and Recovery Act (CARA) allowing partial filling of prescriptions for controlled substances.

Discussion for a first opiate prescription [Utah Code 58-37-19]
Before issuing an initial opiate prescription*, a prescriber must discuss with the patient, or the patient's parent or guardian:

- The risks of addiction and overdose associated with opiate drugs;
- The dangers of taking opiates with alcohol, benzodiazepines, and other central nervous system depressants;
- The reasons why the prescription is necessary;
- Alternative treatments that may be available; and
- The risks associated with the use of the drugs being prescribed.

* "Initial opiate prescription" includes a prescription for a patient who was last prescribed an opiate more than a year ago.

This discussion is not required for:

- A patient who is currently in active treatment for cancer;
- A patient who is receiving hospice care from a licensed hospice; or
- A medication that is being prescribed to a patient for the treatment of the patient's substance abuse or opiate dependence.

Restriction on certain NPs to prescribe Schedule II or III drugs [Utah Code 58-31b-803]
Nurse Practitioners in independent solo practice and who 1) have been licensed less than a year or 2) have less than 2000 hours of practice experience may prescribe or administer Schedule II or III Controlled Substances only if they have a consultation and referral plan (CRP) with a physician or an APRN who has at least 3 years of practice experience.

Limitations on PAs' prescribing or administering Schedule II or III drugs [Utah Code 58-70a-501]
Physician Assistants holding a Utah Controlled Substances license may prescribe or administer Schedule II or III controlled substances within the prescriptive practice of the supervising physician and within the delegation of services agreement (DOSA) between the supervising physician and PA.

Prescribing or dispensing an opiate antagonist [Utah Code 26-55-104]
A prescriber-patient relationship is not required for a prescriber to prescribe or dispense an opiate antagonist to an at-risk person, a concerned person in a position to help, or an overdose outreach provider.

Lay persons who administer an opiate antagonist are protected from civil liability when acting in good faith.

As provided by this law, on December 8, 2016, the physician-executive director of the Utah Department of Health issued a standing order allowing pharmacists to dispense naloxone to concerned family members, caregivers, friends, and patients without a written prescription. However, pharmacies are not required to participate in the standing order.

Electronically generated prescriptions [21 CFR Subpart C. Electronic Prescriptions]
Prescribers using electronic medical records may generate prescriptions for controlled substances. Signatures for these prescriptions may be computer generated for Schedule III through V substances; Schedule II substances may also be computer generated when the prescriber has obtained a two-factor authentication credential.

Emergency Spoken Prescriptions [R156-37-605]
A prescriber may give a spoken prescription for a Schedule II drug when:

- Quantity dispensed is only enough to cover the patient for the emergency period, 72 hours max;
- The prescriber has examined the patient within the past 30 days and the patient is under the continuing care of the prescriber for a chronic condition; or the prescriber is covering for another provider and has knowledge of the patient's condition; and
- A written prescription is delivered to the pharmacist within 7 working days of the spoken order.

Document prescriptions in patient records [R156-37-603(9)]
Each prescription for a controlled substance and the number of refills authorized shall be documented in the patient records by the prescribing practitioner.

Maintain records separately from other records [R156-37-602(5)]
All records relating to Schedule II controlled substances received, purchased, administered, or dispensed by the practitioner shall be maintained separately from all other records of the pharmacy or practice.

Duty to report significant opiate drug diversion [Utah Code 76-10-2204(2)]
Any individual who knows of a practitioner or employee involved in diversion of a Schedule II or III opiate >500 MME is required to report the diversion to a peace officer or law enforcement agency. Failing to report is a class B misdemeanor.

Controlled Substance Database

Laws and Rules [https://dopl.utah.gov/csd/index.html]
The Utah Division of Occupational and Professional Licensing (DOPL) maintains the CSD Program. Access to the data is provided to authorized individuals by going online at https://dopl.utah.gov/ >Programs>Controlled Substance Database.

Employees designated to access CSD [Utah Code 58-37f-301(2)(i)]
A prescriber can designate one or more employees who can access the CSD on the prescriber's behalf. Individuals who are licensed to prescribe controlled substances in Utah or staff assigned by the prescriber must register with DOPL to access the CSD.

Third party notified when controlled substance is dispensed [Utah Code 58-37f-301(5)]
A patient with a controlled substance prescription may designate a third party who will be notified by DOPL when a controlled substance is dispensed to the patient. The controlled substance is not identified in the notification. When the patient tells the division to stop providing information to the designated party, the designee will be notified of the change. Prescribers should discuss this designation with patients.

Check CSD before prescribing for the 1st time or if repeatedly prescribing [Utah Code 58-37f-304(2)]
A prescriber must check the database before the first time the prescriber issues a patient a Schedule II or III opioid prescription. A prescriber is also required to periodically check the database or similar records if the prescriber is repeatedly prescribing Schedule II or III opioids to a patient. The CSD check is not required 1) in an emergency situation; 2) when the CSD is not working; or 3) when the internet is not working.

Education is offered if prescribing guidelines are not followed [Utah Code 58-37f-304(5)]
DOPL shall review the database to identify any prescriber who has a pattern of prescribing opioids not in accordance with the recommendations of CDC Guidelines for Prescribing Opioids, Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, or other best practices publications. DOPL will offer the prescriber education on best opioid prescribing practices. The prescriber may accept or decline the offered education. Note: This is not a standard of care. DOPL may also review cases for other regulations they have adopted by rule.

CONTINUING MEDICAL EDUCATION

Controlled substances education required for professional license renewal [Utah Code 58-37-6.5]
Health care providers licensed to prescribe controlled substances are required to complete 3.5 hours of DOPL-approved continuing education on Schedule II and III controlled substances that are applicable to opioid narcotics, hypnotic depressants, or psychostimulants. The education may be used toward the continuing education hours required every two years for licensure renewal specific to their discipline. However, dentists are required to complete only 2 hours of controlled substances education.
The UMA Foundation offers a 3.5 credit hour course, Controlled Substances: Education for the Prescriber and can be found at https://cme.utahmed.org/. Additional DOPL approved courses may be found at https://dopl.utah.gov/.

Healthcare providers must complete 3.5 hours of SBIRT training prior to their respective professional license renewal in 2026. This training can be used to fulfill the above controlled substances education requirement. A licensee need only take the SBIRT training class once during the controlled substances prescriber's licensure.

Register with DOPL to access CSD [Utah Code 58-37f-401]
Within 30 days of obtaining a Utah Controlled Substance License, a licensee is required to complete an online tutorial about the Controlled Substances Database (CSD), pass an exam about the CSD, and register with DOPL for access to the CSD. As of May 8, 2018, licensees are no longer required to re-take the tutorial and exam before renewing their licenses.

Substance Use Disorder Treatment

Remuneration for referrals – Third degree felony [Utah Code 62A-2-116(5)]
Offering, soliciting, paying, or promising to pay, or receiving remuneration for the referral of an individual for substance use disorder treatment is a third-degree felony. Remuneration includes any commission, bonus, kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in-kind, or engaging in any split-fee arrangement. Some exceptions apply.

Resources

Utah Division of Occupational and Professional Licensing Controlled Substance Database
https://dopl.utah.gov/csd/index.html

Utah Bill Search
https://le.utah.gov/solrsearch.jsp

Utah Controlled Substances Act
https://le.utah.gov/xcode/Title58/Chapter37/58-37.html

Utah Controlled Substances Act Rule
https://rules.utah.gov/publicat/code/r156/r156-37.htm

Utah Controlled Substances Database Act
https://le.utah.gov/xcode/Title58/Chapter37F/58-37f.html

Utah Controlled Substances Database Act Rule
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