Arizona Department of Health Services (ADHS)
Opioid Prescribing Guidelines for Chronic Non-Terminal Pain

February 1, 2016

Dear Care1st Practitioners and Office Staff:

These guidelines are intended to reduce the inappropriate use of controlled substances, improve safety, and reduce harm while preserving the vital roles of clinicians and patients in the management of acute chronic pain issues.

Treatment of acute or chronic pain in any setting is challenging. Progress can be made through awareness of opioid prescribing pitfalls. Success can be achieved by putting into practice the following basic principles:

1. Utilize a comprehensive pain management assessment tool
2. Assess for substance use, behavioral health issues and risk of opioid misuse
3. Refer member to appropriate specialty services based on assessment
4. Review the AZ Controlled Substance Prescription Monitoring Program (CSPMP)
5. Request initial urine drug test and then random tests throughout treatment
6. Discuss the rules of the signed pain management contract with each patient
7. Consider all forms of non-opioid treatment to manage the patient's pain
8. Prescribe at the lowest possible dose to achieve treatment goals
9. Counsel patients regarding non-opioid pain management techniques and practices
10. Review the CSPMP prior to prescribing to determine morphine/diazepam equivalent daily dose, multiple providers, potential misuse or pain contract violations

Please review Clinical Guidelines & Recommendations - Prescribing Guidelines:
http://azdhs.gov/clinicians/clinical-guidelines-recommendations/index.php?pg=prescribing

If you have any questions regarding these guidelines, call our Pharmacy Team at 602.778.1800 or 866.560.4042 (Options in order: 5, 5)

Thank you

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SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF CHRONIC NON-TERMINAL PAIN (CNTP)

#1: A comprehensive medical and pain related evaluation that includes assessing for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.

#2: A goal directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks. The patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive behavioral therapy when these therapies are recommended and available.

#3: The provider should assess for risk of misuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.

#4: Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal directed trial lasting 30-90 days should be the starting point. Continuing opioid treatment after the treatment trial should be a deliberate decision that weighs the risks and benefits of chronic opioid treatment for that patient. A second opinion or consult with a pain specialist may be useful.

#5: When a trial of opioid therapy is determined to be appropriate, patients should be actively engaged in a process of education, shared decision-making, and informed consent. The provider should obtain and document informed consent including discussion of risks, benefits, and conditions under which opioids are prescribed or discontinued. Documentation of this discussion is ideally accomplished by using a signed Opioid Pain Care Agreement (OPCA).

#6: Clinicians treating patients with opioids for chronic pain should obtain and review past records when possible. Ongoing medical records should document the patient evaluation, a treatment plan with clearly defined goals, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant drug-related behavior observed.

#7: For patients on chronic opioid therapy (COT), monitoring progress and adherence to the treatment plan is essential to optimize patient care and the overall benefit to risk profile. Appropriate monitoring for COT includes, at a minimum: (1) regular assessment with face to face encounters (2) assessment of response to therapy including assessment of the 6 A's (analgesia, activity, aberrant drug related behaviors, adverse effects, affect, and adjuncts), (3) periodic query of the AZ Controlled Substances Prescription Monitoring Program, and (4) periodic completion of UDT. Frequency of monitoring should be determined by risk category.

#8: Clinicians should consider consultation, when available, for patients with: complex pain conditions, serious co-morbidities including mental illness, a history or evidence of current drug addiction or abuse, patients who are pregnant or breastfeeding, or when the provider wants help managing the patient.

#9: An opioid treatment trial should be tapered/discontinued if the goals are not met and opioid therapy should be tapered/discontinued at any point if risks outweigh benefits or if dangerous or illegal behaviors are demonstrated.

#10: COT should be used in the lowest possible doses to achieve treatment goals. Opioid related adverse events increase with doses > 50-100 mg of morphine equivalent dose per day (MEDD) and reaching these doses should trigger a re-evaluation of therapy.

#11: Combined use of opioids and benzodiazepines should be avoided if possible. If this combination is used, it should be with great caution and informed consent should be obtained. Particular caution should also be exercised when opioids are used with other sedatives/hypnotics.

#12: Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use and who are prepared to conduct the necessary careful monitoring. Methadone should generally not be prescribed to opioid naïve patients and particular caution should be used if methadone is prescribed for opioid naïve patients.

SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF ACUTE PAIN

The goal of these guidelines is to balance the appropriate treatment of pain with approaches to more safely prescribe opioids. Thoughtful opioid prescribing for acute and post-operative pain can improve safety, reduce harm, and prevent the unintended or inappropriate long-term use of opioid medications.

Note: These guidelines are not intended to apply to hospice or palliative care patients (as defined by the World Health Organization), patients at end of life, or cancer-related pain.

#1: Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice, and non-opioid pain medications or therapies will not provide adequate pain relief.

#2: When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. This should be based on the expected duration of pain severe enough to justify prescribing opioids for that condition.

#3: When opioid medications are prescribed for acute pain, the patient should be counseled on the following:

- Sharing with others is illegal.
- Medications should be stored securely.
- Medications should be disposed of properly when the pain has resolved to prevent non-medical use of medications.
- Opioids are intended for short-term use only.
- Driving or operating machinery should be avoided if a patient is sedated or confused while using opioids.

#4: Long acting opioids should not be used for treatment of acute pain, including post-operative pain, except in select opioid tolerate patients and situations where monitoring and assessment for adverse effects can be conducted.

#5: The continued use of opioids should be considered carefully, including assessing the potential for misuse. If pain persists beyond the anticipated treatment duration, then the patient should be carefully reevaluated.

#6: The Arizona Controlled Substances Prescription Drug Monitoring Program should be checked prior to prescribing opioids and periodically if renewing opioid prescriptions.

For more information on the Arizona Opioid Prescribing Guidelines, visit
http://azdhs.gov/clinicians/clinical-guidelines-recommendations/