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

August 19, 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

http://www.cdc.gov/drugoverdose/prescribing/guideline

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

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.

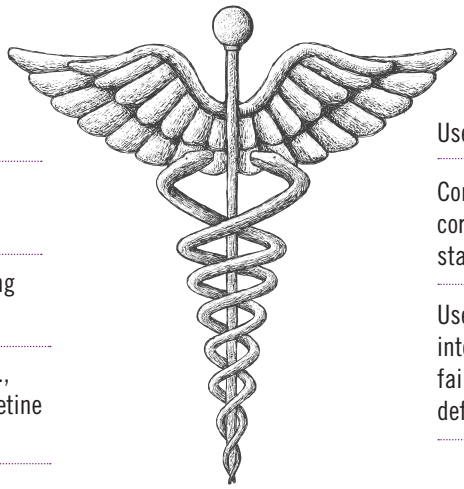
#6: The Arizona Controlled Substances Prescription Drug Monitoring Program should be checked prior to prescribing opioids and periodically if renewing opioid prescriptions.

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

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:



- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

Medication	Magnitude of benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (i.e. brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin

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Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (**PDMP**): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

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