CommonSpirit

Outpatient Opioid Toolkit

A service of the CommonSpirit Health Physician Enterprise and Enterprise Population Health

September 2020

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Appendix

Prescribing Guidelines and Opioid Checklist

1. Before writing an initial prescription (for opiate naïve patients only, not chronic patients)		Perform a patient risk assessment
		Obtain and review the patient's PDMP (Prescription Drug Monitoring Program) report for every new patient.
		Controlled Substance Informed Consent Form (page 4-5)
		A maximum 7-day supply (recommended) if treatment is for acute pain, no more than 14 days
		Schedule a reassessment in 1-4 weeks
		RX should be for no more than 50 MME (Opiate naïve patients) daily
2. Components of a written controlled substance prescription		International Classification of Diseases 10th revision (ICD-10) diagnosis code for the disease being treated with the CS (ICD-10 reason for meds needs to be in chart or on prescription, depending on state law)
		Rx fewest number of days necessary
3. Prescribing after 14 days		Controlled Substance Agreement (see pages 4-5)
4. Prescribing after 90 days		Determine an evidence-based diagnosis for the cause of the pain
		Set criteria for reducing, stopping, or continuing with the patient
		Obtain and review the patient's PDMP report at least every 90 days during the course of treatment
		Obtain a urine screening every 6-12 months, frequency up to provider 1. Random drug screens by "immunoassay" have certain issues including: a. Each community laboratory may have a different set of drugs that they screen for. b. Immunoassay can miss drugs at "low levels" and does not "quantify" levels. c. There are both false negatives (particularly at low levels) and false positives based on certain interactions (for instance robitussin can create a false positive for PCP) 2. The "gold standard" is Gas Chromatography Mass Spectroscopy a. It can be ordered for individual drugs and in this case you can obtain and actual drug level and therapeutic range. b. One can also order a GC Mass Spectroscopy for general unknowns – each lab may have a different panel of what is included. i. This tends to be expensive, ranging from $200-$700, and may or may not be covered by insurance. 3. Random drug screens by immunoassay and Gas Chromatography Mass Spectrometry for general unknowns vary by laboratory and locality; therefore it is important for each provider or medical group to assess and standardize urine drug screening in their community 4. Urine screening panels from Quest Diagnostics: • Panel 6 (may be called Pain Management Panel 6) Code: 92456 includes testing for commonly used substances including alcohol and prescribed narcotics. They do screening and then confirmatory tests on positive results. • Panel 7 – Code: 92490 includes all of the tests on panel 6 but also includes buprenorphine for followup of suboxone patients. 5. Appropriate diagnosis codes include Z79.891 – Long-term current use of opioid analgesic, F11.20 – Opioid Dependence (for suboxone followup), and G89.4 – Chronic pain syndrome.
		If the patient is receiving a dose that exceeds 90 MME daily – Consider referring patient to a pain management specialist – Develop and document in the patient's medical record a revised treatment plan including an assessment of increased risk for adverse outcomes
5. CDC Recommendations		1. Opioids are not first-line therapy 2. Establish goals for pain and function 3. Discuss risks and benefits 4. Use immediate-release opioids when starting 5. Use the lowest effective dose 6. Prescribe short durations for acute pain 7. Evaluate benefits and harms frequently 8. Use strategies to mitigate risk 9. Review PDMP data 10. Use urine during testing 11. Avoid concurrent opioid and benzodiazepine prescribing 12. Offer treatment for opioid use disorder
6. See Appendix		

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"

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

CS273808A

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

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

www.drugabuse.gov/nidamed-medical-health-professionals

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Controlled Substance Informed Consent Form

Before starting any medication, including those containing narcotics, you should be aware of any potential side effects.

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s).

- **Common side effects include:**
  - Constipation
  - Itching
  - Nausea
  - Vomiting
  - Sedation
  - Lightheadedness
- **Uncommon side effects include:**
  - Swelling in the legs
  - Water on the lungs
  - Trouble breathing (especially if you have emphysema/COPD or are on other narcotics)
  - Slower thinking and loss of coordination
  - Reduced sex drive, decreased testosterone (male sex hormone)
  - Addiction
- **Narcotic-Induced Hyperalgesia:** Narcotic-induced Hyperalgesia is a condition associated with long-term narcotic use. It causes you to be more sensitive to pain.

  Note: Pregnant women using narcotics could make their newborn child dependent upon opioids. If you are pregnant, alert your health care provider.

Risks

- Physical dependence with one or more of the following:
  - Runny nose
  - Difficulty sleeping for several days
  - Diarrhea
  - Abdominal cramping
  - Sweating
  - “Goose bumps”
  - Fast heart rate
  - Nervousness
- Psychological dependence
- Tolerance
- Addiction
- Problems with pregnancy. If you are pregnant or are thinking about becoming pregnant, talk to your physician.
- Controlled substances when abused or overdosed may cause dangerous adverse effects such as seizures or unresponsiveness. These effects may be treated or reversed with a drug called “Naloxone”.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then goes into withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

ADDICTION: Addiction is not the same as dependence. Many people become dependent on daily opioids. Only a small percentage of these people will become addicted. Signs of addiction include loss of control of drug use, compulsive use and cravings, and continued use despite harm or risk to the person. A person who is addicted is not taking opioids simply to treat pain.

WITHDRAWAL: If you suddenly discontinue your medication after taking it routinely, around the clock, for several days or weeks, you may experience unpleasant symptoms also known as "withdrawal". Symptoms include upset abdominal pain, diarrhea, chills, or shakes. In some situations, consuming opioids or benzodiazepines may lead to abuse or addiction.

I have read and understood this document. I have had all of my questions answered to my satisfaction. I understand that in keeping with federal law, doctors in this medical group do not recommend marijuana for pain control. I agree to the use of opioids to help control my pain. I understand that my treatment with opioids will be carried out as described above.

Time:_____ Date: _____ Patient Signature: _____

Time:_____ Date: _____ Patient Signature: _____

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CONTROLLED SUBSTANCE INFORMED CONSENT FORM

PATIENT IDENTIFICATION

Patient Name: _____

DOB: _____

Opiate (Narcotic) Informed Consent Form

Before starting any medication, including those containing narcotics, you should be aware of any potential side effects.

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s).

- Common side effects include:
  - Constipation
  - Itching
  - Nausea
  - Vomiting
  - Sedation (getting sleepy)
  - Lightheadedness
- Uncommon side effects include:
  - Swelling in the legs
  - Water on the lungs
  - Trouble breathing (especially if you have emphysema/COPD or are on other narcotics)
  - Slower thinking and loss of coordination
  - Reduced sex drive, decreased testosterone (male sex hormone)
  - Addiction
- **Narcotic-induced hyperalgesia:** Narcotic-induced hyperalgesia is a condition associated with long-term narcotic use. It causes you to be more sensitive to pain.

Note: Pregnant women using narcotics could make their newborn child dependent upon opioids. If you are pregnant, alert your health care provider.

Risks

- **Physical dependence**: When you have physical dependence and then stop the medication it can cause one or more of the following:
  - Runny nose
  - Difficulty sleeping for several days
  - Diarrhea
  - Abdominal cramping
  - Sweating
  - “Goose bumps”
  - Fast heart rate
  - Nervousness
- Psychological dependence (an emotional desire to take the medication)
- Tolerance
- Addiction
- Problems with pregnancy. If you are pregnant or are thinking about becoming pregnant, talk to your physician.
- Controlled substances when abused or overdosed may cause dangerous adverse effects such as-seizures or unresponsiveness. These effects may be treated or reversed with a drug called “Naloxone”.

Alternative Treatment Options

Depending on the cause of your pain, there are other options available to you which may include the following:

- Less addictive medications
- Non-addictive medications
- Physical therapy, yoga, strength training
- Cognitive behavioral therapy
- Surgery or injections (only in certain circumstances)
- Suboxone (If you have opiate misuse disorder)

Please discuss these options with your physician.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then goes into withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

ADDICTION: Addiction is not the same as dependence. Many people become dependent on daily opioids. Only a small percentage of these people will become addicted. Signs of addiction include loss of control of drug use, compulsive use and cravings, and continued use despite harm or risk to the person. A person who is addicted is not taking opioids simply to treat pain.

Five Characteristics of Addiction/Use Disorder (ASAM)

1. Craving for drug or reward
2. Diminished recognition of significant problems in one's behavior
3. Dysfunctional emotional response
4. Impairment in behavioral control
5. Inability to consistently abstain

WITHDRAWAL: If you suddenly discontinue your medication after taking it routinely, around the clock, for several days or weeks, you may experience unpleasant symptoms also known as "withdrawal". Symptoms include upset abdominal pain, diarrhea, chills, or shakes. In some situations, consuming opioids or benzodiazepines may lead to abuse or addiction.

I have read and understood this document. I have had all of my questions answered to my satisfaction. I understand that in keeping with federal law, doctors in this medical group do not recommend marijuana for pain control. I agree to the use of opioids to help control my pain. I understand that my treatment with opioids will be carried out as described above.

Time:_____ Date: _____ Patient Signature:_____

Time:_____ Date: _____ Patient Signature:_____

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OPIATE INFORMED CONSENT FORM

PATIENT IDENTIFICATION

Patient Name: _____

DOB: _____

Benzodiazepine Informed Consent Form

Before starting any medication, including those containing benzodiazepines, you should be aware of any potential side effects. Benzodiazepines are controlled substances.

SIDE EFFECTS: Most patients do not have serious side effects. Unfortunately, some do experience side effects and must stop the medication(s).

- **Common side effects include:** Drowsiness, fatigue, sedation, ataxia (losing coordination), memory impairment, Irritability, cognitive dysfunction (not thinking straight), slurred speech, depression.
- **Uncommon side effects include:** Low blood pressure, confusion, disinhibition, agitation, vertigo, weight gain or weight loss, addiction

Note: Pregnant women using benzodiazepines could make their newborn child dependent upon benzodiazepines. It can cause low birth weight, low muscle tone (so that they don't move well), poor breathing and low blood sugar in your baby right after birth. If you are pregnant or breast feeding, alert your health care provider.

Overdose: In general, overdose causes a coma and rarely death, UNLESS the medication is taken with OTHER SUBSTANCES, such as alcohol, narcotics or other sedating medications. Mixing this medication can lead to death, so discuss your different medications with your doctor.

Risks

- **Physical dependence:** When you have physical dependence and then stop the medication suddenly it can cause one or more of the following:
  - Tremors (shaking)
  - Anxiety
  - Perceptual disturbances (your senses like sight not working correctly)
  - Dysphoria (just not feeling right)
  - Psychosis (thoughts and emotions being so disrupted that you lose touch with reality)
  - Seizures
- Psychological dependence (an emotional desire to take the medication)
- Addiction
- Tolerance
- Problems with pregnancy. If you are pregnant or are thinking about becoming pregnant, talk to your physician.
- Controlled substances when abused or overdosed may cause dangerous adverse effects such as-seizures or unresponsiveness. These effects may be treated or reversed with a drug that is available only in the emergency department.

Alternative Treatment Options

Depending on why you are taking this medication, there are other options available to you which may include the following:

- Non-addictive medications
- Cognitive behavioral therapy
- Yoga, relaxation techniques, meditation

Please discuss these options with your physician.

DEPENDENCE: Dependence is not the same as addiction. Many people who take benzodiazepines daily will become dependent on them. Dependence is when your body adapts to the medication and then goes into withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include tremors, anxiety, perceptual disturbances, dysphoria, psychosis and even seizures.

ADDICTION: Addiction is not the same as dependence. Many people become dependent on daily benzodiazepines. Only a small percentage of these people will become addicted. Signs of addiction include loss of control of drug use, compulsive use and cravings, and continued use despite harm or risk to the person. A person who is addicted is not taking benzodiazepines simply to control anxiety or spasms.

Five Characteristics of Addiction/Use Disorder (ASAM)

1. Craving for drug or reward
2. Diminished recognition of significant problems in one's behavior
3. Dysfunctional emotional response
4. Impairment in behavioral control
5. Inability to consistently abstain

WITHDRAWAL: If you suddenly discontinue your medication after taking it routinely, around the clock, for several days or weeks, you may experience unpleasant symptoms also known as "withdrawal". Symptoms are listed above. In some situations, consuming opioids or benzodiazepines may lead to abuse or addiction.

I have read and understood this document. I have had all of my questions answered to my satisfaction. I understand that in keeping with federal law, doctors in this medical group do not recommend marijuana with these medications. I agree to the use of benzodiazepines for the symptoms discussed with my doctor.

Time:_____ Date: _____ Patient Signature:_____

Time:_____ Date: _____ Patient Signature:_____

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BENZODIAZEPINE INFORMED CONSENT FORM

PATIENT IDENTIFICATION

Patient Name: _____

DOB: _____

Controlled Substance Agreement

Treatment Agreement for Chronic Controlled Substance Use

Several medications are classified as Controlled substances. This is because they have significant risk of being taken incorrectly which can become misuse disorder or addiction.

Five Characteristics of Addiction/Use Disorder (ASAM)

1. Craving for drug or reward
2. Diminished recognition of significant problems in one's behavior
3. Dysfunctional emotional response
4. Impairment in behavioral control
5. Inability to consistently abstain

Overdose, or combining medications, can cause over sleepiness or even death. This is also true when combining the medications with marijuana or alcohol, so it is important to discuss this with your provider.

Narcotics are medicines that can control long-term (chronic) and short-term pain and allow greater ability to do activities that you need to do in your daily life. However they can stop breathing in overdose.

Stimulants, such as Dexedrine, are used for attention deficit disorder, narcolepsy, and other neurologic problems.

Benzodiazepines, such as Xanax or Valium, are sedatives. They are often used for anxiety and sleep disorders, as well to relax muscles.

There are several other medications that are controlled. Some are Schedule V, and while they have some abuse potential, it is considered fairly low.

As with any drug, share your concerns or questions with your doctor.

Because of the risks of controlled substance use, we are cautious when prescribing them. We also ask our patients to understand certain rules and procedures before we start or continue these drugs. These are in place to help us **keep you safe**. Failure to follow these guidelines may result in us stopping these medications. You also may be dismissed from our care.

What You Need To Do

- Know that medications containing controlled substances are only one part of treatment.
- Keep your appointments. Chronic treatment requires a visit to the doctor at least every three months. Visits may need to be more often if a change in dose or medication is necessary.
- Take your medications ONLY as directed by your provider.
- Work with your provider. Follow other treatment recommendations in addition to taking prescribed medications.
- Read and sign this Controlled Substance Agreement and the appropriate

Patient Agreement

I understand that I must do the following:

- I will take medications only as prescribed (the amount and frequency).
- I will not increase or change medications without my doctor's approval.
- I will not ask for or accept controlled substance medication from any other doctors than this doctor, unless there is prior agreement from both physicians.
- I will tell this doctor about all other medications that I am taking.
- I will tell this doctor about any marijuana or alcohol use.
- I will get all medications from one pharmacy, when possible.
- I will protect my prescriptions and medications. And I will not share, trade or sell my medications with anyone.
- I understand that lost medications will not be replaced.
- I understand that if my medications are stolen the doctor will consider replacing them only if there is a police report.
- I will not use illegal or street drugs.
- I understand that I consent to random drug screening.
- I understand that my provider is required to check my prescription use in the Prescription Drug Monitoring Program.
- I will keep my scheduled appointments. If I can't, I will cancel or re-schedule at least 24 hours prior to the appointment.
- I understand that my doctor may stop prescribing controlled substance medications or change the treatment plan if:
  - My symptoms or ability to function have not improved.
  - I do not fulfill my responsibilities listed above.
  - I give, sell or misuse my medications.
  - I develop rapid tolerance or loss of improvement from the treatment.
  - There are unexpected medications or substances on the Prescription Drug Monitoring Program or in my drug screen.
  - I refuse or an unable to cooperate when asked to get a drug screen.
  - I am unable to keep follow-up appointments.
- I understand that I am expected to keep my controlled substance or pain medication in a safe and secure place, such as a locked cabinet. If my medication is stolen, I understand that I am responsible to file a report with my local police department and provide a copy of this report.
- I understand that I am responsible and expected to return unused, unneeded, or expired prescription drugs to retail pharmacies or police stations.
- I understand that I must avoid alcohol, can't consume benzodiazepines with opioids, drive a car, or operate dangerous machinery while using sedating controlled substances (this does not apply to stimulants).
- I will pay attention to when I need refills and call in at least three days before I need to pick them up.

Provider Agreement:

Taking controlled substance medications inappropriately **can cause physical harm.**

- As your doctor, I have an obligation to cause no harm. Therefore I will not start or continue these drugs if you as a patient cannot comply with these terms.
- I will only refill them during normal business hours, not after hours or on call.
- I will discuss any warning signs of addiction with you frankly, and without judgement.
- I will safely stop the medications with clear instructions if I believe that they are not helping you, or if in my medical judgement, they are harming you.
- My practice partners will not refill these medications unless I am out of the office for more than a couple of days.

We as a patient and provider agree to the above statements. We both have had a chance to discuss the use of these medications and believe that this agreement is valid and complete.

Time:_____ Date: _____ Patient Signature: _____

Time:_____ Date: _____ Patient Signature: _____

CommonSpirit

CONTROLLED SUBSTANCE AGREEMENT

PATIENT IDENTIFICATION

Patient Name: _____

DOB: _____

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

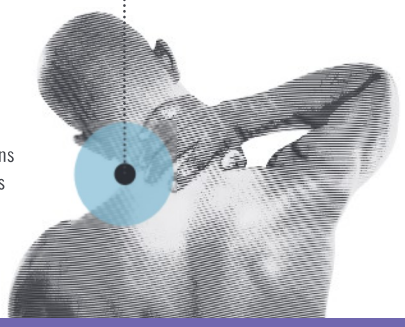
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



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Centers for Disease Control and Prevention

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

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

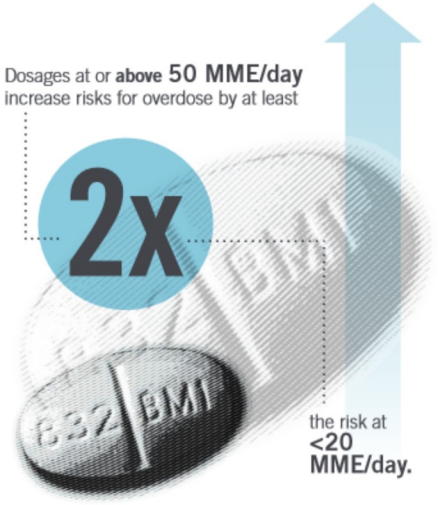
- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

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

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

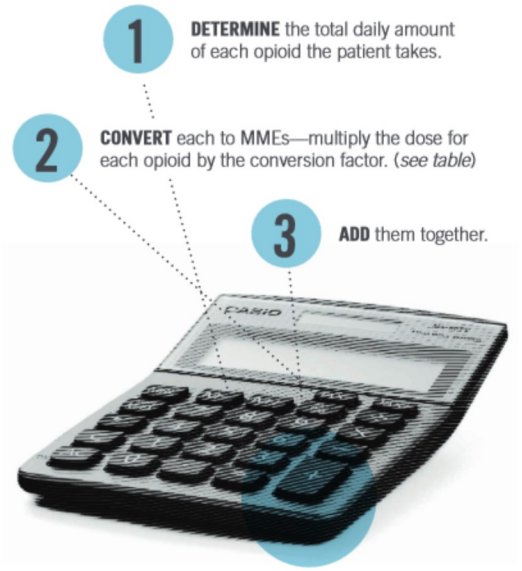
90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

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

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

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

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

CDC Opioid Guideline by Centers For Disease Control and Prevention
~App with Opioid Calculator~

itunes.apple.com/us/app/cdc-opioid-guideline/id1185581887?mt=8

WHAT IS MEDICATION-ASSISTED TREATMENT (MAT)?

1 WHAT IS MAT?

- MAT uses both medication and cognitive-behavioral therapy to treat substance abuse disorders

2 HOW DOES MAT WORK?

- MAT reduces cravings and withdrawals
- The dosage decreases over time and this allows the individual to return to daily activities

3 WHY USE MAT OVER OTHER TREATMENTS?

- MAT is more effective than medication or behavioral therapy alone
- The WHO has deemed MAT the most effective treatment for Opioid Use Disorders (OUD)

4 AREN'T PATIENTS JUST SUBSTITUTING ONE DRUG FOR ANOTHER?

NO:

- MAT can't give users euphoria like other opioids
- MAT can be tapered down and doesn't need to be increased to have the same effect

PATIENTS BENEFIT FROM MAT

MAT SAVES LIVES

50% Less Fatal Overdoses

INCREASING THE AVAILABILITY OF MAT LED TO A 50% REDUCTION IN FATAL OVERDOSES IN BALTIMORE FROM 1995-2009.

(Volkow, N. D., et al, 2014)

PATIENTS ARE MORE LIKELY TO RECOVER ON MAT

- MAT is the ***most effective*** treatment for opioid use disorders. (WHO, 2004)

MAT PROMOTES LONG-TERM RECOVERY (Hatfield , R., 2017)

PATIENTS ARE MORE LIKELY TO STAY IN TREATMENT

(Volkow, N. D., et al, 2014)

PATIENTS LIVE HEALTHIER LIVES

- There are no long-term negative effects on bodily organs and patients engage in less risky behaviors. (Fields, J., et al., 2004)

EPIC

THE OHIO STATE UNIVERSITY
COLLEGE OF SOCIAL WORK

Source: Ohio State University and Caileigh Chadwick

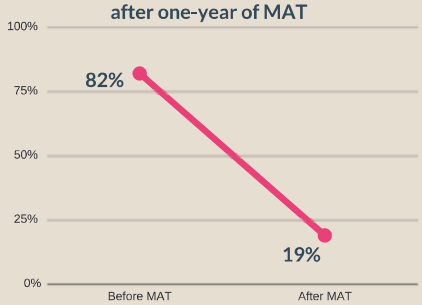
Medication Assisted Treatment (MAT) and X-Waivered Prescribing

"Medication-assisted treatment *saves lives* while increasing the chances a person will remain in treatment and learn the skills and build the networks necessary for *long-term recovery*."

- Michael Botticelli, Director, National Drug Control Policy

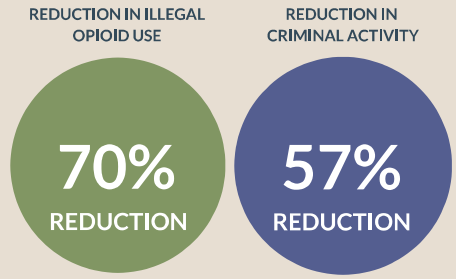
MAT BENEFITS SOCIETY

Patients are less likely to be arrested after one-year of MAT



(Fields, J., et al., 2004)

MAT reduced illegal opioid use and criminal activity

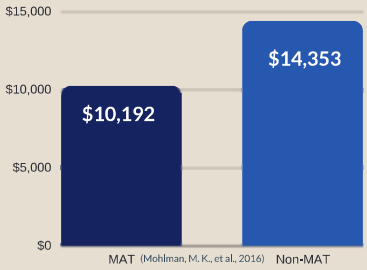


(Fields, J., et al., 2004)

Patients are more likely to be employed full-time

(Fields, J., et al., 2004)

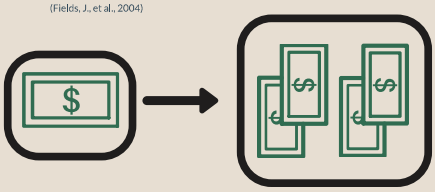
Cost of Health Plan for MAT Patients vs Non-MAT Patients



(Mohlman, M. K., et al., 2016)

For every $1 spent on MAT, $4 is saved.

(Fields, J., et al., 2004)



WHAT ARE BARRIERS TO USING MAT?

- MAT is expensive in the short-term, but results in long-term savings
- There is a myth that MAT is replacing one drug for another
- Patients may feel shame or a lack of support
- Insurance may not always cover MAT

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Made by Caileigh Chadwick

Source: Ohio State University and Caileigh Chadwick

MAT Q&A

Q: Is addiction, like opioid use disorder, something that I can treat?

A: Yes, addiction is a chronic disease of the brain that requires chronic, long-term treatment, similar to other chronic diseases. And there are very effective treatments available, especially for opioid use disorder, which can be offered in many clinical settings, including primary care.

Q: What is MAT?

A: Medications for Addiction Treatment (MAT) or Medication Assisted Treatment uses medication, often in conjunction with mental health services (such as cognitive-behavioral therapy) and recovery support, to treat opioid use disorder (OUD). MAT is a whole-person approach and requires patient readiness. Treatment helps patients normalize body and social function.

MAT medications include methadone, buprenorphine, and naltrexone. Buprenorphine can be prescribed by a licensed provider in many clinical settings, including primary care, and is very effective at treating OUD.

Q: How does MAT work?

A: The prescribed medication operates to normalize brain chemistry, block the euphoric effects of opioids and relieve physiological cravings and distress without the negative effects of misused opioids. More specifically, buprenorphine's unique pharmacology as a partial opioid agonist makes it effective at reducing cravings, withdrawals, and the risk of opioid overdose. MAT is long-term, chronic, longitudinal treatment that is prescribed by a licensed clinician (see X-Waiver licensing information below).

Q: What are the benefits of MAT? (OSU, 2020)

A: There are many benefits of MAT, including:

- **MAT saves lives:** increasing the availability of MAT has led to reductions in fatal overdoses (Volkow, 2014)
- **MAT helps support long term recovery:** patients are more likely to stay in addiction treatment and sustain recovery from drug use (Ling, 2012)
- **MAT keeps patients out of the criminal justice system:** MAT and addiction treatment reduces illegal opioid use and criminal activity (Hubbard, 2003)
- **MAT improves the quality of life for patients and their social networks:** MAT and addiction treatment is associated with more stable employment and a returning to normalized daily activities (Hubbard, 2003)
- **MAT is harm reduction:** MAT reduces a person's risk of contracting HIV, hepatitis C, and other serious blood borne infections by reducing the potential for return to drug use and minimizing harm from intravenous drug use practices (Woody, 2014)
- **MAT is cost-effective:** numerous studies have shown lower total medical costs, lower ED usage, and shorter hospitalization lengths of stay for MAT patients (Mohlman, 2016)
- **MAT can improve birth outcomes:** MAT use during pregnancy has been shown to reduce risks to babies with neonatal abstinence syndrome (NAS) and improve birth outcomes among pregnant women who have a substance use disorder (Klaman, 2017)

Q: How do I start to prescribe MAT?

A: Clinicians, both physicians and advanced practice providers, can be licensed to prescribe buprenorphine for OUD. This requires a DEA x-waiver license that clinicians can receive after completing a brief set of special trainings (8 hours for physicians and 24 hours for advanced practice providers). This training can happen in person or online. More information can be found online through the Substance Abuse and Mental Health Services Administration (SAMHSA) or Providers Clinical Support System (PCSS) websites. Receiving your x-waiver license is simple and worthwhile. And starting to prescribe buprenorphine will help you transform the lives of your patients struggling with addiction.

For additional questions, please contact Dr. Julian Mitton at Julian.Mitton@DignityHealth.org.

For more information, watch the MAT video here.

Sources

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California Medication Assisted Treatment Expansion Project Prescriber Toolkit

Revised July 2018

Background

The Drug Addiction Treatment Act of 2000 (DATA 2000) **permits qualified physicians to prescribe buprenorphine (and other Schedule III, IV, and V narcotic medications) in settings other than opioid treatment programs**. DATA 2000 reduces the regulatory burden on physicians who choose to practice opioid dependency treatment by allowing them to apply for waivers of the special registration requirements defined in the Controlled Substances Act.

On July 22, 2016, President Obama signed the Comprehensive Addiction and Recovery Act (CARA) into law as Public Law 114-198. Among CARA's provisions is the **expansion of the prescribing privileges for buprenorphine in office-based settings to qualifying nurse practitioners (NPs) and physician assistants (PAs)** until October 1, 2021.

Physician Requirements for DATA 2000 Waiver

Qualifying for a Physician Waiver

A "qualifying physician" is specifically defined in DATA 2000 as one who is:

- Licensed under state law;
- Registered with the Drug Enforcement Administration (DEA) to dispense controlled substances;
- Capable of referring patients to counseling services; and
- Qualified by training and/or certification.

DATA 2000 Physician Criteria

Physicians are considered qualified for a DATA 2000 Waiver if they meet **one or more** of the following criteria, with supporting documentation:

- Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.
- Hold an addiction certification from the American Society of Addiction Medicine (ASAM).
- Hold a subspecialty board certification in addiction medicine from the American Osteopathic Association.

- Have completed required training for the treatment and management of patients with opioid use disorders. This involves, at minimum, eight hours of training through classroom situations, seminars at professional society meetings, electronic communications, or training otherwise provided by ASAM and other organizations.
- Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic medication in Schedule III, IV, or V for maintenance or detoxification treatment. The physician's participation should be confirmed in a statement by the sponsor of the approved medication to Department of Health and Human Services (HHS). Drug scheduling definitions are available from the DEA for scheduled medications.
- Have other training or experience that the state medical licensing board (of the state in which the physician will provide maintenance or detoxification treatment) considers a demonstration of the physician's ability to treat and manage patients with opioid dependency.
- Have completed other training or experience that HHS considers a demonstration of the physician's ability to treat and manage patients with an opioid dependency. The criteria of HHS for this training or experience will be established by regulation.

Waiver Training

Under the DATA 2000 requirements, physicians must complete an 8-hour training to qualify for a waiver to prescribe and dispense buprenorphine. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a **list of supported continuing medical education (CME) courses** that can help physicians qualify to prescribe buprenorphine in an office setting. These courses may require registration and include fees.

Application Process

Follow these steps to apply:

1.	Ensure you meet and have documentation showing you are a qualifying physician.
2.	Complete the required 8 hours of training to prescribe and dispense buprenorphine.
3.	Fill out the Waiver Notification Form.
4.	Send SAMHSA all supporting documentation, including the 8-hour training certificate, via email to infobuprenorphone@samsha.hhs.gov or fax to (301) 576-5237.

Expedited Application

To receive permission to provide treatment while your waiver application ('notification') is under review:

1.	Check the box "New Notification, with the intent to immediately facilitate treatment of an individual (one) patient" on the notification form.
2.	Meet the criteria for obtaining a Waiver (i.e., having a valid medical license, valid DEA registration, completed eight hours of qualifying training).
3.	Contact SAMHSA's Center for Substance Abuse Treatment (CSAT)'s Buprenorphine Information Center (866)-BUP-CSAT to verify that the notification for has been received and notify CSAT of your intention to begin treatment for one patient.

Review Process

SAMHSA reviews waiver applications within 45 days of receipt. If approved, physicians receive a letter via email that confirms their waiver and includes their prescribing identification number.

Waiver Restrictions

Once a physician has been granted a waiver to prescribe buprenorphine, they may have a maximum of 30 patients in opioid dependence treatment at a time for the first year. One year after the initial notification is submitted, the physician may submit a second notification of the need and intent to treat up to 100 patients.

Nurse Practitioner (NP) and Physician Assistant (PA) Requirements for DATA 2000 Waiver

Waiver Training

Under the DATA 2000 requirements, NPs and PAs must complete an 8-hour training to qualify for a DATA 2000 Waiver to prescribe and dispense buprenorphine. SAMHSA maintains a list of supported continuing medical education (CME) courses that can help providers qualify to prescribe buprenorphine in an office setting (courses may require registration and include fees).

Application Requirements

CARA requires that NPs and PAs complete, at minimum:

- 24 hours of training to be eligible for a prescribing waiver. The 24 hours of initial training must cover each of the following topics (21 USC 823(g)(2)(G)(ii)(IV))[1]:
  - Opioid maintenance and detoxification;
  - Appropriate clinical use of all drugs approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorder;
  - Initial and periodic patient assessments (including substance use monitoring); o Individualized treatment planning, overdose reversal, and relapse prevention; o Counseling and recovery support services;
  - Staffing roles and considerations;
  - Diversion control; and
  - Other best practices, as identified by the Secretary of Health and Human Services.
- An 8-hour DATA-waiver course; and
- An additional 16 hours of free training offered SAMHSA through the Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT)

[1] The training must be provided by one of the following organizations: ASAM, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary of Health and Human Services determines is appropriate.

1.	Complete the 24-hour training to become an eligible prescriber.
2.	Complete the required 8 hours of training to prescribe and dispense buprenorphine.
3.	Complete the additional 16-hour training from SAMHSA.
4.	Fill out the Waiver Notification Form.
5.	Send SAMHSA all supporting documentation, including 8-hour training certificate, via email to infobuprenorphone@samhsa.hhs.gov or fax to (301) 576-5237.

Review Process

NP and PA Waiver applications are forwarded to the DEA and assigned a special identification number. DEA regulations require both this number and the NP or PA's regular DEA registration number to be included on all buprenorphine prescriptions for opioid dependency treatment.

SAMHSA reviews the waiver applications within 45 days of receipt. If approved, NPs and PAs receive a letter via email that confirms their waiver and includes a unique prescribing identification number.

Resources for Prescribers

There are several helpful resources available to support subscribers once they receive a waiver. Below are a few examples, including an app, research, and an opioid safety support network.

- App: SAMHSA MATx Mobile App to support Medication Assisted Treatment of Opioid Use Disorder
- Clinical Guidelines and Research:
  - Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SAMHSA)
  - The ASAM Standards of Care for the Addiction Specialist Physician
- Other
  - California Health Care Foundation Opioid Safety Network

Six Building Blocks

A Team-Based Approach to Improving Opioid Management in Primary Care

What are the Six Building Blocks?

The Six Building Blocks, described below, are six key work areas you can redesign to improve your clinic's management of patients who are on long-term opioid therapy. Learn more at www.improvingopioidcare.org.

What is the Six Building Blocks Program?

The Six Building Blocks Program supports primary care teams in implementing effective, guideline-driven care for their chronic pain and long-term opioid therapy patients. The Six Building Blocks Program is a tailored approach that offers a variety of kinds of support to match an organization's needs and time. The following tables provide an overview of the types of services we can offer.

Comprehensive QI facilitated program

The below table outlines an evidence-based program for implementing opioid management improvements supported by a trained practice facilitator.

Content	Time and commitment
Guidance in implementing comprehensive opioid management system-based improvements. This is the full Six Building Blocks Program, which includes: • Guided assessment • In-person kickoff event • Action plan development support • Connection to resources and education • Facilitated shared learning calls • Ad-hoc assistance	9-15 months Opioid improvement team (clinical champion, QI project manager, data manager, others as desired) will: • Provide vocal, engaged leadership throughout the Six Building Blocks program. • Create an opioid improvement team that typically includes a clinical champion, a program manager, a tracking and monitoring lead, and others from the clinic as desired. • Regularly update action plans to achieve milestones. • Provide protected time for a designated staff member to develop and begin implementing an approach to tracking and monitoring patients on long-term opioid therapy, including: — updating patient data, as necessary; — generating reports for patient care planning; — generating regular performance reports. • Provide protected time for the opioid improvement team to meet internally at least once each month to review and assess progress and data, and make plans to continue the improvement work. • Provide time to participate in calls with the practice facilitator. • Provide time for the clinical champion and other clinicians and staff to participate in clinical education.

Other types of support available

If your organization does not have the capacity or interest in the full program, we can also offer individual components of the program, as described below.

Service	Service Six Building Blocks facilitator commitment	Clinic commitment	Time
Six Building Blocks consultation	Six Building Blocks facilitator will: • Provide focused, facilitated guidance in doing an in-depth assessment • Identify areas for chronic pain and opioid management improvement during a "give back" meeting	Clinical champion and QI project manager will: • Work with the Practice Facilitator to complete a clinic self-assessment • Gather existing resources	1-3 months
Technical assistance	Six Building Blocks facilitator will: • Provide ad-hoc support and technical assistance in opioid management areas, as needed. For example: – Policy development/revision to align with WA 1427 – Workflow development/revision to support policy implementation – Creating a tracking and monitoring system	Clinical champion and QI project manager will: • Work with the practice facilitator to assess needs • Implement action plans	Ad-hoc
Shared Learning Calls	Monthly facilitated shared learning calls between clinics engaged in opioid management improvement work.	A representative from the opioid improvement team will: • Attend monthly calls where other clinics engaged in opioid management improvement work share successes and brainstorm how to overcome challenges.	Ongoing
Targeted education	Educational opportunities in opioid management areas, such as: • Opioid tapering • Empathic communication • Identifying patients with opioid use disorder • Cannabinoids and pain	To be determined based on clinic needs	Ad-hoc
Intro to Six Building Blocks	Introduction to the Six Building Blocks approach and resources to support opioid management improvements. Can include follow-up check-in calls.	Team working on opioid management will: • Attend a virtual call to learn about the Six Building Blocks approach and resources.	One meeting

How do I choose between these support options?

We would be happy to talk this through with you to determine what makes the most sense for your organization.

SIX BUILDING BLOCKS: INTRODUCTORY HANDOUT | VERSION 2020.07.21

The Six Building Blocks program was developed by the University of Washington Department of Family Medicine and Kaiser Permanente Washington Health Research Institute. Funded by Agency for Healthcare Research & Quality (#R18HS023750, #HHSP233201500013I), Washington State Department of Health (CDC #5 NU17CE002734), National Institute on Drug Abuse (#UG1DAO13714), and the Washington State's Olympic Communities of Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of AHRQ, WA DOH, NIDA, or WA DOH.

APPENDIX

We care about you and your safety.

Our goal is to treat your medical conditions, including pain, safely.

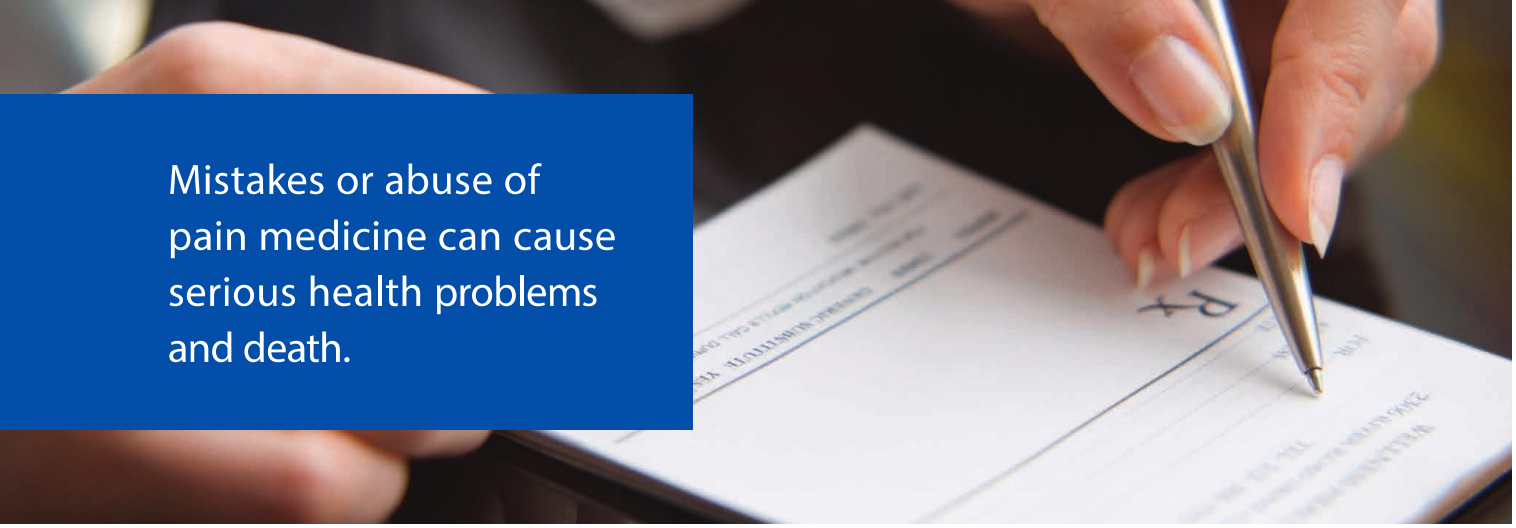
Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death. A list of pain management and alternative treatment clinics is available upon request.

These recommendations follow legal and ethical advice.

1. You should have only **ONE** provider and **ONE** pharmacy helping you with pain.
2. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we will only give you a limited amount.
4. We do not routinely refill stolen prescriptions. We do not refill lost prescriptions.
5. We do not routinely prescribe long-acting pain medicines such as: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Exalgo, and others.
6. We do not provide missed doses of Subutex, Suboxone, or Methadone.
7. Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
8. Use (your state's) Drug Monitoring Program. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.

If you need help with substance abuse or addiction, please call 000-00-0000 for confidential referral and treatment

Dignity Health.



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CHI Texas Health Network
Clinically Integrated Network

2. Risk Reduction and Overdose Prevention in Opioid Prescribing

Opioids cause more than 100 overdose deaths a day in the United States. Many of these are unintentional. Providers should consider and screen for potentially harmful behaviors that put patients, and their families, at risk of overdose. Potentially harmful behaviors include:

A high-volume use of opioids

Taking opioids in combination with alcohol, benzodiazepines, or other respiratory depressants

Using illicit opioids or other illicit drugs

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that providers offer education that can reduce the risk for overdose and consider a naloxone prescription in certain situations.

Risk reduction education from a provider may include information about safe storage and disposal of opioids, as well as a review of which other medications a patient is taking that are respiratory depressants (including benzodiazepines, some anti-seizure, and many psychiatric medications), in addition to letting patients know that mixing opioids with other respiratory depressants or taking more opioids than prescribed may increase their risk of overdose.

Naloxone is a life-saving opioid overdose reversal medication. Providers should prescribe naloxone in certain situations. Naloxone distribution has not been shown to increase drug misuse but rather has been associated with an increase in treatment engagement. SAMHSA advises providers to encourage at-risk patients to create an "overdose plan" to share with friends, family, and/or caregivers. A plan should include information on the signs of overdose and how to administer naloxone. At-risk patients include individuals:

Who are taking higher dosages of opioids (>50 MME/day)

With a history of overdose

With a history of substance use disorder

Who are taking benzodiazepines with opioids

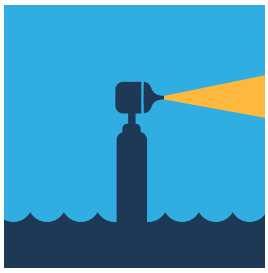
Who are at risk for returning to a high opioid dose to which they are no longer tolerant (e.g., individuals recently released from prison, patients leaving detoxification facilities).

Risk Reduction and Overdose Prevention in Opioid Prescribing

A Harm Reduction Approach to Opioid Use Disorder

Addiction is a chronic disease of the brain that requires chronic, long-term treatment. Return to drug use, or relapse, is an expected part of the disease course. Patients can return to use despite their best intentions to remain in treatment. As compassionate providers, informed by evidence and best clinical practices, we are obliged to care for all of our patients with opioid use disorder by offering patient-centered treatment and minimizing potential harms associated with drug use. This is called a harm reduction approach. We can minimize harms by doing the following:

Based on CDC and SMAHSA guidance/recommendations



Looking to avoid risk?

WE CAN SHOW YOU THE WAY.

NAVIGATING THE OPIOID EPIDEMIC

November 2017

THE DOCTORS COMPANY
medical ~~mal~~practice insurance

YOUR PATIENTS AND YOUR PRACTICE ARE AT RISK

As the death toll from opioid-related harms continues to rise, so does uncertainty about how doctors can help patients safely relieve pain. And new research suggests that opioid-related overdose deaths may have been significantly underreported.[1]

> "With approximately 142 Americans dying every day, America is enduring a death toll equal to September 11th every three weeks,"[2] says the President's Commission on Combating Drug Addiction and the Opioid Crisis. In response, the president has declared a national public health emergency. Several governors have also declared emergencies for their states.

Just as opioid addiction and overdose impact families from all walks of life, the opioid crisis affects doctors and providers across the practice spectrum.

Dr. Roneet Lev, chief of the Emergency Department at Scripps Mercy Hospital in San Diego, puts the problem to doctors in plain, personal terms: "Does your name show up on a Prescription Drug Monitoring Program (PDMP) report of someone who died from a medication you prescribed?" She explains, "Unfortunately, some medications we prescribe with good intentions end up causing harm."[3]

THE OPIOID CRISIS

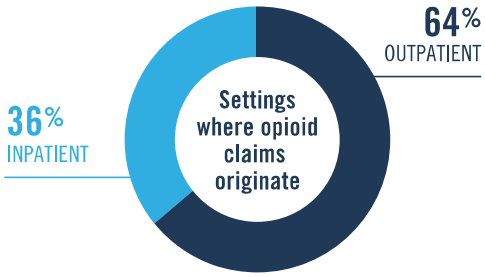
1. The United States consumes 99 percent of the world's hydrocodone.
2. The number of annual opioid prescriptions written in the United States is roughly equal to the number of adults in the country.
3. Thirty-eight percent of teens have misused or abused prescription drugs obtained from the home medicine cabinet.
4. One of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years after the first prescription.
5. In 2015, 19,000 Americans died of an opioid overdose, and the death rate from all opioids (including heroin) now exceeds the death rate from motor vehicle accidents.[4]

> Former Centers for Disease Control (CDC) Director Tom Frieden noted: "We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.[5]

ANALYSIS OF OPIOID-RELATED CLAIMS

The Doctors Company studied 272 claims that closed between 2007 and 2015 in which opioids resulted in patient harm. Contributing factors to opioid-related claims included:

- Inappropriate selection and management of therapy.
- Errors in patient monitoring.
- Inadequate patient assessment for risks and contraindications to opioids.



- Failure in communication among providers.
- Insufficient documentation and/or support for clinical decision making.
- Failure to take psychiatric and/or abuse history.
- Communication errors with patients and their families, including insufficient warning of risks of opioids.
- Patient factors, including noncompliance with treatment plans and follow-up appointments.

The study revealed that 64 percent of the claims originated in the outpatient setting.

FIGURE 1

Outpatient settings

78%	Physicians' offices and hospital clinics
10%	Ambulatory and day surgery centers
9%	Emergency rooms
3%	Patient's home

The specific opioids that lead to claims in both the inpatient and outpatient settings were also identified.

FIGURE 2

Opioids involved in claims

	INPATIENT	OUTPATIENT
Methadone	4%	16%
Oxycontin	3%	9%
Dilaudid	34%	10%
Morphine	24%	15%
Fentanyl	16%	11%

THE UNUSUAL NATURE OF OPIOIDS

Prescription opioids (mu receptor agonists) are no less addictive than heroin, and the increase in prescription opioids fuels illicit drug use. The dramatic increase in heroin addiction and related deaths has accelerated as a result of the low street price of heroin, compared to the relatively high cost of Percocet.[6]

While physicians prescribe many medications with high risk/benefit ratios and a narrow therapeutic window, the high opioid complication rate is unique—largely because opioids induce euphoria, have a high potential for addiction, and have a therapeutic endpoint (i.e., suppression of pain) that is subjective. Healthcare providers must work to prevent opioid misuse and addiction while protecting the well-being of patients experiencing the devastating effects of acute or chronic pain.

WHEN TO PRESCRIBE OPIOIDS, AND HOW TO PRESCRIBE SAFELY

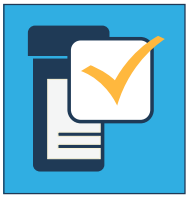
Dr. Tom Frieden, former director of the CDC, has characterized prescribing an opioid as a "momentous decision." Below, we share some key considerations from the CDC's guidelines*.[7]

The Basics

According to the CDC, prescribers should:

- Avoid prescribing opioids for chronic pain (three-plus months) except for cancer patients and palliative care for end of life.
- When prescribing opioids for acute pain (post injury or surgery): "Start low and go slow."
- Choose faster-acting options instead of extended-release/long-acting (ER/LA) medications.[8]
- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that nonopioid therapies have been tried and optimized.
- Discuss benefits and risks (e.g., addiction, overdose) with patient. Evaluate risk of harm or misuse.
- Discuss risk factors with patient.
- Check PDMP data.
- Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (i.e., PEG scale).
- Schedule initial reassessment within one to four weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.[9]

THE PRESCRIBER'S DOZEN



Below, we summarize the CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care. To read the CDC's complete guidelines, go to www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm#B1_down.

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If prescribing opioids, combine them with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Establish treatment goals with all patients, including realistic goals for pain and function. Consider how therapy will be discontinued if benefits do not outweigh risks.
3. Before starting and periodically during opioid therapy, discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

*The CDC guidelines are guidelines, not rules. They are not enforceable, and are not applicable to all patients in all cases. These guidelines do not replace a physician's judgment regarding an individual patient's needs, or a physician's judgment regarding whether benefits outweigh risks in a given instance.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. Prescribe immediate-release opioids instead of ER/LA opioids.
5. Prescribe the lowest effective dosage. Use caution when prescribing opioids at any dosage.
6. For acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
7. Evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, optimize other therapies and work with patients to taper opioids to lower dosages or to discontinuation.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, evaluate risk factors for opioid-related harms. Incorporate strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages ≥50 morphine milligram equivalents (MME) per day, or concurrent benzodiazepine use, are present.
9. Review the patient's history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.
10. Use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Note: All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guidelines for evidence ratings.

WHEN DISCUSSING A PRESCRIPTION, "ASK ME 3"

To promote clear communication, the National Patient Safety Foundation offers a patient education program called "Ask Me 3."

The Ask Me 3 program is a time-efficient, effective tool that encourages the patient to participate in his or her own healthcare by understanding the answers to three questions:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

The Ask Me 3 approach involves letting the patient speak a little longer at the start of an appointment, prior to the physician interrupting, knowing that most patients won't speak for more than two minutes. Fewer interruptions can lead to less confusion and more clarity on the part of patients. The Ask Me 3 program also

encourages attention to communication factors like the respective seating levels of physician and patient. Most importantly, during the visit, the patient is provided with a preprinted Ask Me 3 form and instructed to write down the answers to the three questions in the presence of the physician.

Educational materials to implement the Ask Me 3 program may be downloaded free from www.npsf.org/askme3.[10]

TAPERING A PRESCRIPTION FOR OPIOIDS

To make life easier for physicians and safer for patients, the CDC has prepared their *Pocket Guide: Tapering Opioids for Chronic Pain*.[11] Major points include:

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

- Requests dosage reduction.
- Does not have a clinically meaningful improvement in pain and function (i.e., at least 30 percent improvement on the 3-item PEG scale).
- Is on dosages ≥50 MME per day without benefit or opioids are combined with benzodiazepines.
- Shows signs of substance use disorder (i.e., work or family problems related to opioid use, difficulty controlling use).
- Experiences overdose or other adverse event.
- Shows early warning signs for overdose risk such as confusion, sedation, or slurred speech.

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

Opioid tapering tips

HOW TO TAPER
Go Slow Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.
Consult Use extra caution and care in conversations with patients during pregnancy, due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.
Support Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.
Encourage Tell patients "I know you can do this" or "I'll stick by you through this."
CONSIDERATIONS WHEN TAPERING
Adjust Adjust the rate and duration of the taper according to the patient's response.
Monitor Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
Reduce 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.

In addition to the CDC guidelines, the following suggestions are useful:

- **Rule number one** is don't prejudge patients as being pain seeking when there is a potential for missed diagnosis.
- **The gold standard** is for patients to use one provider and one pharmacy for all chronic medications.
- **Do not use the emergency department** as a referral for patients who run out of medications or extra shots. Many emergency departments have established guidelines that refer patients back to their physicians for all chronic medications.
- **The PDMP makes you a better doctor** by telling you more than doctor shopping information. It gives you medication names and dosages and the names of the doctors prescribing them. Take one to two minutes to check that your patient has no drug interactions or co-prescribing. If your patient is already receiving opioids from another provider for a different diagnosis, you do not need to prescribe more.
- **Use medication agreements** for patients who need more than three months of a controlled medication. This can include opioids, benzodiazepines, and stimulants.
- **Give clear discharge instructions.** Warn patients not to drive when taking opioids, sleep aids, or anything that causes them to not be fully alert. Warn patients to keep medications secure.
- **Treat addiction with compassion**, like other medical illnesses. About one percent of the population suffers from addiction, and only 10 percent get appropriate treatment. There is often a genetic association, and it is useful to ask about a family history. Learn your community resources for addiction. Addiction referral can be helpful for patients you are weaning from multiple medications.[12]

Suggested responses to patient questions and scenarios

PATIENT QUESTION	DOCTOR ANSWER
"Can't I have something for pain?"	"Yes, let me check your medical record for the best choice."
"The medicines don't work."	"Can you please tell me how you take the prescription?"
"My prescription was stolen."	"Did you file a police report?"
"I have chronic pain."	"For your safety, you need your medications coordinated by one doctor and one pharmacy."
"I received extra pain medications elsewhere."	"Let's do a drug specimen today." "I see you received 20 pills from the emergency department, what happened?" "OK, to stay on the same schedule, this month I will write 100 tablets (120 minus 20)."
PATIENT SCENARIO	**DOCTOR RESPONSE**
A case of clear doctor shopping.	"I am concerned because your medications can be addicting. I am going to refer you to someone who can help with this."
A case of need to stop an opioid prescription.	"The medication no longer appears to be as beneficial as it once was. As the benefits of the opioids no longer outweigh the risks, we need to discontinue this approach and together find a safer and more effective means of dealing with your pain."

COMPLIMENTARY OPIOID MANAGEMENT COURSES

The Doctors Company is pleased to offer complimentary on-demand continuing education courses that focus on opioid prescribing and management. Find details on these and all of our on-demand courses and upcoming seminars and webinars at thedoctors.com/cme.

SUMMARY

Opioids are powerful, and the risk of their misuse, accidental or otherwise, rises when patients don't understand their medications, highlighting the value of clear communication. The doctor-patient relationship is as important as ever.

In communicating directly with patients and families, those delivering care have a special and vital role to play in reducing harm from opioids to keep their patients and their practices safe.

Remember,

- Start low and go slow.
- Do not start without a plan to stop.
- For more help with opioid safety, consider taking one of our complimentary continuing education courses. Visit thedoctors.com/cme for details.

CASE STUDY

INNOVATION IN PAIN MANAGEMENT AND OPIOID ADDICTION: NORTH AMERICAN PARTNERS IN PAIN MANAGEMENT

One practice on Long Island, New York, has developed an innovative, personalized approach to pain management—and to helping patients wean themselves off addiction to opioids.

"We literally have this problem on our doorstep every day," said Adam E. Shestack, MD, a member of the medical staff at North American Partners in Pain Management (NAPPM). Dr. Shestack is also Director of Outpatient Pain Medicine Services at Syosset and Plainview Hospitals, and serves as a pain management specialist at North Shore University Hospital in Manhasset.

"In our practice, we see new patients daily with legitimate pain management issues who are on enormous amounts of narcotics or opioids," said Dr. Shestack. "For years, opioids were first-line therapy for pain. Now, with primary care physicians no longer prescribing opioids, these patients don't know what to do. They've never had their pain managed by anything other than medication. They have nowhere else to go."

Patients in Nassau County do have somewhere to go—NAPPM.

A division of North American Partners in Anesthesia, NAPPM focuses on short and long-term pain relief with interventional pain management solutions that can also help restore functionality and ease mobility. NAPPM's physicians are board certified in anesthesiology and pain medicine, and are trained to manage complex acute or chronic pain. The practice, led by John Stamatos, MD, also employs a board-certified psychiatrist who specializes in addiction psychiatry, advanced practice nurses certified in pain management, and a family nurse practitioner.

"For some patients who come to us, they have been on high doses of medication for so long that they no longer remember where their pain comes from," Dr. Shestack said.

He adds that patients who do not have access to a practice like NAPPM usually end up in one of three places: in emergency rooms, in detox units, or somewhere where they can obtain medication illegally—not to get high, but to prevent withdrawal from medication prescribed to them for many years.

"These patients are also often suffering from depression, some can no longer work, and for many their relationships are failing," said Dr. Shestack. "Some are on anxiety medication. For those also on narcotics, they are at risk for morbidity or mortality."

The NAPPM pain management specialists first stabilize these patients, then begin learning about their pain and their history. "When we have patients who tell us they can no longer get medication, we call their primary care physicians for verification. We talk to prescribers too, so we can learn why medication is no longer being prescribed."

Once they become patients of the practice, a personalized risk tool for every patient is put into motion:

- Patients are subject to urinalysis on a random basis.
- Clinicians run New York's Internet System for Tracking Over-Prescribing (I-STOP) at each patient visit.
- Doctors follow up on notes from other providers, including physical therapists, also at each visit.

At NAPPM, opioids are the last line of treatment. "We'll prescribe them only when everything has failed," says Dr. Shestack. "And by 'everything else,' I mean all medications, injections, spinal cord stimulations; all other evaluations and treatments. Only then will we prescribe opioids to help meet the goals of therapy."

Addicted patients are often referred to NAPPM's addiction psychiatrist, Maryn Sloane, MD. Dr. Sloane also operates A Second Chance Center, NAPPM's pain management mental health center.

"Dr. Sloane helps patients reveal other issues in their lives, including substance abuse, sexual abuse, history of alcoholism—there is often a strong correlation between these issues and their addiction," said Dr. Shestack.

Patients who maneuver through the system to simply obtain drugs are also treated at NAPPM. "Let's say a patient tests for cocaine," said Dr. Shestack. "So I won't prescribe anything. But I also won't kick them out of the practice. We'll treat them on an outpatient basis. They have a chronic illness. They need treatment too."

This approach to pain management and opioid addiction is unique, and succeeds because of the relationships with patients. "We want to know a patient's goals," said Dr. Shestack. "We find out their baseline work functionality, their personal relationships, their physical expectations. It's different for every patient. And we treat them all."

He added that the practice tried to involve families and friends whenever possible, so everyone is on the same page and supports their loved ones and keeps them motivated.

"We're looking for better modalities now," he concluded. "Narcotics are not the treatment of choice. They change you as a person. People come in asking us to treat their pain. We'll do that, but our goal is to improve their functioning. When you can work, when your relationships improve, when you have better range of motion, you'll focus less on your pain. I'm a firm believer in that."

Learn more at NAPPM.com.

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4. Kessler Psychological Distress Scale (K10)

Source: Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, et al. Screening for serious mental illness in the general population. Arch Gen Psychiatry. 2003 Feb;60(2):184–9.

The Kessler Psychological Distress Scale (K10)[1] is a simple measure of psychological distress. The K10 scale involves 10 questions about emotional states each with a five-level response scale. The measure can be used as a brief screen to identify levels of distress. The tool can be given to patients to complete, or alternatively the questions can be read to the patient by the practitioner.

In the context of injury management, the measure can be provided to the patient where recovery is not proceeding as anticipated (for instance, between weeks four and six), and may highlight the need for more regular review, or referral to a specialist health provider such as a psychologist.

Questions three and six do not need to be asked if the response to the preceding question was 'none of the time'. In such cases questions three and six should receive an automatic score of one.

Scoring instructions

Each item is scored from one 'none of the time' to five 'all of the time'. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

Interpretation of scores

The 2001 Victorian Population Health Survey[2] adopted a set of cut-off scores that may be used as a guide for screening for psychological distress. These are outlined below:

K10 Score: Likelihood of having a mental disorder (psychological distress)

- 10–19 Likely to be well
- 20–24 Likely to have a mild disorder
- 25–29 Likely to have a moderate disorder
- 30–50 Likely to have a severe disorder

Kessler Psychological Distress Scale (K10)

Please indicate the answer that is correct for you:	All of the time (score 5)	Most of the time (score 4)	Some of the time (score 3)	A little of the time (score 2)	None of the time (score 1)
1. In the past 4 weeks, about how often did you feel tired out for no good reason?					
2. In the past 4 weeks, about how often did you feel nervous?					
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?					
4. In the past 4 weeks, about how often did you feel hopeless?					
5. In the past 4 weeks, about how often did you feel restless or fidgety?					
6. In the past 4 weeks, about how often did you feel so restless you could not sit still?					
7. In the past 4 weeks, about how often did you feel depressed?					
8. In the past 4 weeks, about how often did you feel that everything was an effort?					
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?					
10. In the past 4 weeks, about how often did you feel worthless?					

References

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5. NEVADA PRESCRIBING RULES

These changes to Nevada law do not impact the authority of practitioners to exercise their professional judgment when treating pain patients; these changes do not compel a practitioner to discharge any patient without a plan for on-going treatment.

PRESCRIBING IN NEVADA

An inside look at changes to nevada laws surrounding prescribing controlled substances for the treatment of pain.

Introduction

Assembly Bill 474 from the 2017 Legislative Session produced many changes to Nevada's laws and procedures for prescribing a controlled substance (CS) for pain. Assembly Bill 239 from the 2019 Legislative Session further modified and refined the laws. This guide is designed to help practitioners understand and comply with the changes made in 2019.

For purposes of this guide, the term "practitioner" means any person licensed to prescribe a CS for human consumption. An "initial prescription" is a prescription originated for a new patient of a practitioner, or a prescription written to begin a new course of treatment for a practitioner's existing patient. The term does not include a prescription written to continue a patient's on-going course of treatment as the patient transfers from one practitioner to another.

In this guide, the key provisions in AB474 are divided into six sections:

1) Components of a written CS prescription
2) Factors to consider before writing wny prescription for a CS
3) Factors to consider before writing an initial prescription
4) Prescribing after 30 days
5) Prescribing after 90 days
6) Prescribing after 365 days

Components of a Written Controlled Substance Prescription

Effective January 1, 2018, every written CS prescription, in addition to the components currently listed in NAC 453.440, must include the following:

- Patient's date of birth
- International Classification of Diseases Tenth Revision (ICD-10) diagnosis code for the disease being treated with the CS
- The fewest number of days necessary to consume the quantity of the CS dispensed to the patient if the patient consumes the maximum dose of the CS authorized by the prescribing practitioner.
- Practitioner's Drug Enforcement Administration (DEA) number

If multiple practitioners' names and DEA numbers are printed on the prescription form, the prescription cannot be filled unless the practitioner clearly indicates which is his or her name and DEA number.

Factors to Consider Before Writing Any Prescription for a CS

Before a practitioner writes any prescription for a CS, the practitioner should consider each of the following factors where applicable:

- Whether there is reason to believe that the patient is not using the CS as prescribed, or is diverting the CS for use by another person;
- Where the patient was previously prescribed the CS, whether it had the expected effect on the patient's symptoms for which it was prescribed;
- Whether there is reason to believe that the patient is using other drugs, including, without limitation, alcohol or another CS that:
  - May interact negatively with the CS prescribed by the practitioner; or
  - Was not prescribed by a practitioner who is treating the patient;
- The number of attempts by the patient to obtain an early refill of the prescription;
- The number of times the patient has claimed that the CS has been lost or stolen;
- Irregular or inconsistent information in the patient's PMP report that may indicate the patient is using the CS inappropriately;
- Whether previous blood or urine tests indicate inappropriate use of the CS;
- The need to verify that unauthorized CS are not present in the patient's body;
- Whether the patient has demonstrated aberrant behavior or intoxication;
- Whether the patient has increased his/her dose of CS without the practitioner's authorization;
- Whether the patient has been reluctant to stop using the CS or has requested or demanded a CS that is likely to be abused or cause dependency or addiction;
- Whether the patient has been reluctant to cooperate with any examination, analysis or test recommended by the practitioner;
- Whether the patient has a history of substance abuse;
- Any major change in the patient's health that would affect the medical appropriateness of the CS;
- Other evidence that the patient is misusing or is addicted to any drug, or is failing to comply with the practitioner's instructions;
- Any other factor that will help the practitioner make an informed decision as to the medical necessity and appropriateness of the CS.

If the practitioner determines in his or her professional judgment, after considering each of the forgoing factors, that the CS is medically necessary and appropriate, the practitioner may prescribe following the guidelines on the following pages.

Before Writing an Initial Prescription

Before writing an initial prescription for a CS, each practitioner must:

- Have a bona fide relationship with the patient[1];
- Establish a preliminary diagnosis and a treatment plan;
- Perform a Patient Risk Assessment (see below);
- Obtain and review the patient's PMP report and determine if the patient has been issued another prescription for the same CS[2];
- Discuss non-CS treatment options with the patient and indicate in the patient's medical record why a CS was prescribed;
- Unless the practitioner determines that the prescription is medically necessary, a practitioner, shall not issue an initial CS prescription for the treatment of pain that prescribes:
  - More than 14-day supply; and
  - More than 90 morphine milligram equivalent (MME) daily for an opiate naive patient (patient who has never received an opioid prescription or the patient 's most recent course of opioid treatment was completed more than 19 days prior to the initial prescription the practitioner is intending to issue); AND
  - The patient completes an Informed Consent (see below).

Patient Risk Assessment

To perform a Patient Risk Assessment, a practitioner must:

- Obtain and review the patient's **relevant** medical history of the patient.
- Conduct a physical examination of the patient directed to the source of the patient' s pain and within the scope of practice of the practitioner.
- If the prescription that exceeds a 30 days' supply:
  - Make a good faith effort to obtain and review any medical records of the patient from any other provider who has provided care to the patient that are relevant to the prescription; and
  - Document efforts to obtain such medical records and conclusions from reviewing such medical records in the patient 's medical record.
- Assess the mental health and risk of abuse, dependency and addiction of the patient using a validated instrument.

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[1]A bona fide relationship is required for all prescriptions under Nevada law and was not changed by AB474 or AB239.

[2]A PMP check is required for all prescriptions for all CS Schedule 11, III, IV, and Schedule V opioids,

Informed Consent

A practitioner shall document in the medical record of the patient a conversation in which a patient provided informed consent. Informed consent is not required to be in writing, however if a written informed consent is provided, the document must be included in the patient's medical record.

Informed consent obtained must include, where applicable, information concerning:

- The potential risks and benefits of using the CS, including the risks of dependency, addiction and overdose;
- The proper use, storage and disposal of the CS;
- Possible alternative treatment options;
- The patient's treatment plan;
- How the practitioner will address requests for refills;
- Risk of CS exposure to a fetus of a childbearing age woman;
- If the CS is an opioid, the availability of an opioid antagonist without a prescription; AND
- If the patient is an unemancipated minor, the risks that the minor will abuse, misuse, or divert the CS, including ways to detect those issues.

Exemptions for Hospice, Palliative, Cancer and Sickle Cell Prescriptions

Each practitioner who prescribes a CS listed in schedule II, III, IV or an opioid that is a CS listed in schedule V for the treatment of pain of a patient who has been diagnosed with cancer, sickle cell disease, or if receiving hospice or palliative care must:

- Have a bona fide relationship with the patient;
- Obtain informed consent or any applicable guidelines for informed consent established by:
  - The Centers for Medicare and Medicaid Services for hospice or palliative care;
  - American Society of Clinical Oncology or similar organization designated by regulation for cancer; or
  - The National Heart, Lung and Blood Institute or a similar organization designated by regulation for sickle cell disease.
- Obtain the patient's PMP report as soon as practical and at least once every 90 days.

Each practitioner who prescribes a CS listed in schedule II, III, IV or V for the treatment of pain of a patient who has been diagnosed with cancer, sickle cell disease, or is receiving hospice or palliative care is **NOT** required to:

- Perform a Patient Risk Assessment;
- Enter into a Prescription Medication Agreement with the patient;
- Adhere to the **initial** prescription days' supply or daily MME requirement

Prescribing after 30 Days

A practitioner who prescribes a CS to treat pain for more than 30 days must, not later than 30 days after issuing the initial prescription, enter into a Prescription Medication Agreement with the patient. The agreement must be part of the patient's record, and the practitioner must update it at least every 365 days while the patient is using the CS or whenever the practitioner changes the treatment plan. The agreement must include:

- Goals of the treatment;
- Patient's consent to drug testing when deemed necessary by the practitioner;
- A requirement that the patient take the CS as prescribed;
- A prohibition on sharing the medication with any other person;
- A requirement that the patient inform the practitioner of:
  - Any other CSs prescribed or taken by the patient;
  - Whether the patient drinks alcohol, uses cannabinoid or illicit drugs;
  - Whether the patient has been treated for side effects or complications relating to the use of the CS;
  - Each state in which the patient previously resided or had a prescription for CS filled;
- Reasons the practitioner may change or discontinue the treatment.

Prescribing after 90 Days

A practitioner who prescribes a CS to treat pain for more than 90 consecutive days must:

- Determine an evidence-based diagnosis for the cause of the pain;
- Complete a Risk of Abuse Assessment validated through peer-reviewed research;
- Discuss the treatment plan with the patient;
- Obtain and review the patient's PMP report at least every 90 days during the course of treatment;
- If the patient is receiving a dose that exceeds 90 MME daily;
  - Consider referring patient to a pain management specialist;
  - Develop and document in the patient's medical record a revised treatment plan including an assessment of increased risk for adverse outcomes.

Prescribing after 365 Days

A practitioner should not prescribe a CS to a patient who has already received 365 days' worth of that CS for a particular diagnosis in any given 365-day rolling period. Similarly, a practitioner should not prescribe more doses of a CS than the patient needs if he or she adheres to the practitioner's dosing instructions for the treatment period. In either scenario, the practitioner may choose to prescribe a larger quantity than the patient needs for the treatment period, so long as the practitioner documents his or her rational in the patient's medical record.

PRESCRIBING IN NEVADA

Prescribing controlled substances (CS) for the treatment of pain (AB 474 and AB 239)

Initial Prescription

Before writing an initial prescription for a CS, each practitioner must:

- Have a bona fide relationship with the pt;
- Establish a preliminary diagnosis and a treatment plan;
- Perform a Patient Risk Assessment (→);
- Obtain and review the pt's PMP report;
  - If the pt has a current prescription for the same CS, the practitioner shall not prescribe the CS **unless they determine it is medically necessary**.
- Discuss non-opioid treatment options with the pt;
- Obtain Informed Consent (→) from the pt;
- If the practitioner decides to write an initial prescription, it must be for **(unless the practitioner determines that a higher quantity is medically necessary)**:
  - ≤ 14-day supply if treating acute pain;
  - ≤ 90 MME daily for an opiate naïve pt.

Prescribing after 30 Days

Continuation of CS for >30 consecutive days the practitioner and pt must enter into a Prescription Medication Agreement, which must include:

- Goals of the treatment;
- Pt's consent to drug testing when deemed necessary by the practitioner;
- A requirement that the pt take the CS as prescribed;
- A prohibition on sharing the CS with any other person;
- A requirement that the pt inform the practitioner,
  - Of any other CS prescribed or taken;
  - Of any alcohol, cannabinoid, or illicit drug use;
  - Treatment received for side effects or complications relating to the CS;
  - Each state in which the pt previously resided or had a prescription for CS filled;
  - Reasons the practitioner may change or discontinue the treatment.

Prescribing after 90 Days

Continuation of CS for >90 consecutive days the practitioner must:

- Determine an evidence-based diagnosis for the pain;
- Complete a Risk of Abuse Assessment validated through peer-reviewed research;
- Discuss the treatment plan with the pt;
- Obtain and review the pt's PMP report every 90 days;
- If the pt has been prescribed a dose that exceeds 90 MME daily
  - Develop a revised treatment plan (including an assessment of increased risk for adverse outcomes) and document in the pt's medical record;
  - Consider referring pt to a pain management specialist.

Prescribing after 365 Days

A practitioner should not prescribe a CS to a pt who has already received 365 days' worth of that CS for a particular diagnosis in any given 365 day rolling period **unless the practitioner determines that it is medically necessary**.

Patient Risk Assessment

- Obtain and review the pt's **relevant** medical history/ records; and
- Conduct a physical examination of the patient **directed to the source of the pt's pain and within the scope of practice** of the practitioner.
- Assess the mental health and risk of abuse, dependency, and addiction of the pt using a validated instrument.
- **If the prescription is ≥ 30 days' supply**
  - Make a good faith effort to obtain and review **any** medical records of the pt from any other provider who has provided care to the pt **that are relevant to the prescription**; and
  - Document efforts and conclusions made from obtaining and reviewing such records in the pt's medical record.

Informed Consent

The practitioner must obtain informed consent after discussing the following with the pt. **The practitioner shall document in the medical record of the pt the conversation in which a pt provided informed consent. If the Informed Consent is in writing, the document must be included in the pt's medical record.**

- The potential risks and benefits of using the CS;
- The proper use, storage, disposal of the CS;
- The treatment plan and possible alternative treatment options;
- Risk of CS exposure to a fetus of a childbearing age woman;
- If the CS is an opioid, the availability of an opioid antagonist; AND
- If the pt is an unemancipated minor, the risks that the minor will abuse, misuse, or divert the CS and ways to detect those issues.

Exemptions for Hospice, Palliative, Cancer and Sickle Cell Prescriptions

Practitioners prescribing CS for the treatment of pain to a pt diagnosed with cancer or sickle cell disease, or is receiving hospice or palliative care must:

- **Have a bona fide relationship with the pt;**
- **Obtain informed consent that meets the requirements in AB 239 or any applicable guidelines for informed consent established by:**
  - **The Centers for Medicare and Medicaid Services;**
  - **American Society of Clinical Oncology;**
  - **The National Heart, Lung and Blood Institute.**

Practitioners prescribing CS for the treatment of pain to a pt diagnosed with cancer or sickle cell disease, or is receiving hospice or palliative care is NOT required to:

- **Perform a Patient Risk Assessment;**
- **Enter into a Prescription Medication Agreement with the pt;**
- **Adhere to the initial prescription days' supply or daily MME requirement.**

Bolded sections are new AB239 language

This information is provided as a courtesy, it does not constitute legal advice, and does not override the specific provisions of Nevada law as applied to a particular set of facts.

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