

# Opioids and Pain - Weighing Risks and Benefits (ER/LA Opioids)

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# OPIOIDS AND PAIN - WEIGHING RISKS AND BENEFITS (ER/LA OPIOIDS)

## Goals

The goal for this module is to train providers to, considering the recommendations for limiting their use<sup>1</sup>, apply a comprehensive understanding of ER/LA drug information, weigh risks vs. benefits of these medications, and use clinical skills involved in initiating treatment with these medications effectively and to decrease risk.

## After completing this module participants will be able to:

- Make decisions regarding initiation of treatment with ER/LA opioids based on a complete history and physical examination and assessment of pain and functioning and pain management and functional goals
- Understand and weigh the risk vs. the benefits of ER/LA opioids before prescribing them for a patient
- Follow local and federal guidelines in prescribing ER/LA opioids and documentation

## Professional Practice Gaps

Opioid misuse and abuse is a grave health concern in the U.S., and is one that continues to grow. The number of emergency department visits due to the non-medical use of prescription analgesics increased from 145,000 in 2004 to 360,000 in 2010<sup>2</sup> (DAWN, 2012). The number of drug poisoning deaths involving opioid analgesics increased from 4,000 in 1999 to 14,800 in 2008<sup>3</sup>. By 2008, opioid analgesics were involved in 40% of all drug poisoning deaths<sup>3</sup>. Also disturbing, every year starting in 2002, there have been at least 1.9 million new non-medical pain analgesic users<sup>4</sup>.

Chronic pain is a very common problem encountered in clinical practice. In a study involving 111 providers (attending physicians, nurse practitioners, physician assistants, and family practice residents), a mean of 37.5% of adult patients seen in a targeted week by any of the participating providers reported having current chronic pain<sup>5</sup>. Furthermore, opioids are very commonly prescribed for chronic pain. In a survey of prescribers (including physicians, physician assistants, and advanced practice nurses), 58% answered that they were “likely” to prescribe opioids for chronic pain. When comparing 2002 and 2012, MEPS estimates showed growth in the total number of outpatient prescription purchases of opioids, rising from 85.9 million to 143.9 million purchases, an increase of 67.5 percent<sup>6</sup>. However, a significant amount of participants disclosed negative beliefs and attitudes about medication abuse and addiction which, they indicated, could complicate patient care and negatively impact clinical practice<sup>7</sup>. In a survey of family physicians, 80% were anxious about prescribing high-dose opioids to persons with chronic nonmalignant pain, and 92.4% did not prescribe opioids to individuals with a history of substance abuse<sup>8</sup>.

Professional organizations of pain specialists, based on expert consensus and review of the research literature, have created clinical guidelines for the use of chronic opioid therapy in chronic non-cancer pain<sup>9</sup>. The guidelines are designed to improve pain treatment outcomes and reduce the risk of prescription drug overdose and diversion. The need for prescribers to do more to prevent diversion can be inferred from studies showing that a majority of patients do not take their pain medication as

prescribed<sup>10</sup> and that the source for the majority of non-medically used prescription drugs is friends or relatives<sup>4</sup>. The need for education and training in the guidelines to avoid diversion and overdose is evident in research linking "doctor shopping" to increased risk for overdose<sup>11</sup>. Furthermore, research by the National Center on Addiction and Substance Abuse at Columbia University (CASA) shows that physicians do not follow key recommendations in evidence-based guidelines for avoiding diversion and overdose<sup>12,13</sup>. CASA has concluded from their research that physicians should receive more continuing medical education related to prescribing and administering controlled substances and identifying, diagnosing, and treating substance abuse and addiction<sup>12</sup>.

A survey of health care facilities regarding pain management practice standards and education revealed gaps in knowledge of pain management, and attitudes that hinder proper acute and chronic pain treatment<sup>14</sup>. While some medical schools have implemented programs that have improved students' attitudes and skills for treating patients with addiction, most medical schools have not<sup>15</sup>. From a national survey of residency programs, only 56.3% of programs required substance use disorder training, with the median number of hours ranging from 3 to 12 hours<sup>16</sup>. In a survey of family physicians, the majority (60%) believed that their training in medical school did not prepare them to manage pain<sup>8</sup>.

### **ER/LA Opioids Practice Gaps:**

Only a few practice gaps regarding the prescribing of extended release/long acting (ER/LA) opioids have been identified in the literature, despite evidence of such gaps in the form of a high overdose rate and addiction rate and their frequent use and misuse. Because of these risks, the CDC guidelines for opioid prescribing recommends they not be prescribed to the opioid naive individual and not in a situation of acute pain<sup>1</sup>. The risk of overdose and death can be greater for ER/LA opioids than other opioids and so practice gaps described above regarding these topics are especially relevant for this subclass of opioids. While ER/LA opioids were only 9% of all opioid prescriptions dispensed in 2009, they represented 22.9 million prescriptions, up from 9.3 million in 2000<sup>17</sup>. In 2009, 3.8 million patients received a prescription for ER/LA opioids in an outpatient setting<sup>17</sup>. Primary care providers are responsible for a large portion of the ER/LA prescriptions: General practice (GP), Family Medicine (FM), D.O.'s plus Internal Medicine, dispense around 44% of these prescriptions<sup>17</sup>. Although primary care physicians may be one of the leading prescribers of opioids, they often leave out pertinent information about the safe use and storage of opioid analgesics during patient counseling<sup>18</sup>, making PCPs an important target audience of our proposed program.

## **INTRODUCTION**

### **Assessing Risk and Benefits**

When deciding to initiate chronic opioid therapy the prescriber must determine whether the perceived risks of taking the medication is outweighed by the potential benefits received. This module will help prescribers weigh the risks and benefits of therapy.

### **Government Regulations**

Opioids are regulated by the government, therefore, prescribers must comply with applicable state and federal law. Federal regulations regarding the prescription of controlled substances are strictly

enforced and awareness of these regulations is essential to good practice. This module will train you to understand and comply with these government regulations.

This module also outlines the indications for starting a patient on opioid therapy.

## CLINICAL CASE - MR. LEWIS

The following case will be used throughout this module to illustrate the guidelines for minimizing risk of chronic opioid therapy.



**Patient:** Mr. Raymond Lewis, A 72 y/o male with pain from diabetic neuropathy

**Scenario:** Mr. Lewis's medical history is significant for onset of type 2 diabetes at 48 y/o. He has been insulin dependent for 7 years, and his diabetic peripheral neuropathy started with a gradual onset of numbness, tingling, and then pain in his feet about 4 years ago. The neuropathy is now constant and mild to moderate during the day, but moderate to severe at night despite all evidence-based, non-opioid, first and second line treatments of tricyclic antidepressants and anti-

epileptic drugs.

Mr. Lewis became addicted to heroin as a young adult and last received methadone treatment 20 years ago. He also has a history of several episodes of treatment for clinical depression, which has not recurred in the past several years. Otherwise, he has no other significant medical history.

Would you know how to:

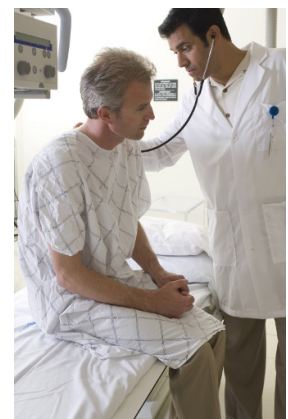
- *Assess Mr. Lewis's current risk for opioid addiction?*
- *Decide whether or not to include opioid therapy in his pain treatment?*

By the end of this module you should be able to answer these questions, "Yes!"

## INDICATIONS FOR OPIOIDS

### General Principles for All Opioids

Evidence-based, first-line therapies including non-pharmacological treatments and scheduled doses of non-opioid medications should be used for each pain condition before prescribing opioids. Opioids are not normally a first-line therapy for many common pain conditions, but they may be needed if severe pain persists after first line treatment has been attempted or when first-line treatments are not possible. Despite opioids not being the first line pain medications for most chronic pain conditions, they have been widely and increasingly prescribed. Recently published guidelines by the CDC are likely to reduce their inappropriate use as they offer specific recommendations. These are summarized on a subsequent page<sup>1</sup>.



- The potential benefits of opioids include decreased pain. Like other therapies, although opioids can reduce chronic pain a few points on a scale of 1 to 10, they generally do not eliminate pain.
- Use the least addictive drug formulation that will adequately manage pain.
- Even patients with a substance abuse history should be appropriately treated with opioids, but with precautions to prevent misuse.
- Use opioids as a part of a multimodal treatment plan, in combination with other pain medications and non-pharmacological treatments (such as physical therapy, exercise, and counseling) to increase effectiveness and minimize the dose.

9,19

## Indications for ER/LA Opioids

FDA guidelines for extended-release/long-acting (ER/LA) opioid prescribing released in September 2013, state that they are for pain that is "severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate"<sup>20</sup>.

Pain should be at least moderately severe to prescribe opioids; some experts now advocate their use only for severe pain. Pain severity can be assessed using a scale of 1 to 10 or other assessment. ER/LA opioids should only be used for severe constant pain resistant to other treatments. A REMS requires that manufacturers provide special training for providers who prescribe ER/LA opioids. Their relatively higher level of risk should be carefully considered.

### PRACTICE TIP

The best measure of treatment success is improved function. It is thus essential to measure existing functioning (e.g., "the pain is so bad I can't work") and to track changes (e.g., "After about 3 hours of work, the pain interferes")

## OPIOIDS FOR ACUTE PAIN

### Examples of Acute Pain

- Acute post-traumatic pain
- Acute post-operative pain
- Dental pain

### PRACTICE TIP

Opioids are prescribed much more often than is indicated for acute pain and without a clear stopping strategy. A patient requesting continued treatment with opioids should be assessed to determine if the initial decision to start opioids was appropriate.

### Before Prescribing

Opioids may be beneficial for severe acute pain with some special precautions and limitations:

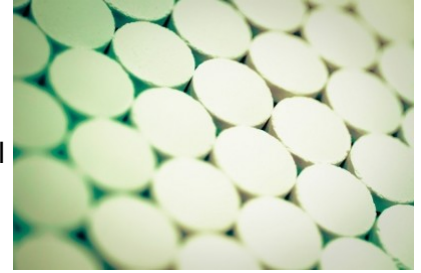
- For severe acute pain efforts should be made to diagnose and treat the underlying condition
- Comorbid conditions may contraindicate use of opioids: e.g., Cognitive impairment, poorly controlled mental health comorbidity, substance abuse history, unstable gait, etc.

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## Prescribing Opioids

- Initially opioids should be prescribed in limited quantities only for the duration of the severe pain, usually  $\leq 3$  days, and in combination with other treatments<sup>1</sup>. For example, in an emergency room the number of doses should be just enough until a regular clinic can be visited.
- Prescribe small quantities for the severe pain phase only. Transition to a non-opioid analgesic, such as acetaminophen, after a few days.
- Don't use extended release/long acting opioids for acute pain.
- Educate patients about 1) safe storage of opioids in a locked container, and 2) safe disposal of any remaining medication.



## After Prescribing

- Dependence and tolerance on opioids can develop within days to weeks.
- For emergency care, recommend follow-up with their regular provider.
- Don't routinely authorize refills unless continued need is verified.

## ACUTE PAIN CASE - MR. ALVAREZ



**Name:** Mr. Eric Alvarez

**Age:** 42 yo male

**Reason for visit:** Acute toe injury

Review Mr. Alvarez's History of Present Illness: Mr. Alvarez was evaluated at a 24-hour urgent care center last night where the physician assistant (PA) on staff indicated that his toe appeared severely bruised but not fractured. The PA secured the toe with tape and offered him a prescription for two days of acetaminophen plus hydrocodone for pain. He was told he should not drive or operate machinery if he took the pain medication. Because he operates machinery in his job, he did not fill the prescription. Now, he is still in pain after taking over-the-counter ibuprofen and is reconsidering getting a prescription for a "stronger" medication.

**Working Diagnosis:** Contusion of the left big toe

## Pharmacological Treatment For Mr. Alvarez

In Mr. Alvarez's case, non-pharmacological interventions alleviated some of his acute, moderate to severe pain. Upon further questioning, the provider found that Mr. Alvarez's use of over-the-counter medications had been limited to ibuprofen which he was not taking often enough. When longer-acting naproxen was combined with acetaminophen, his pain became tolerable at a mild level.

## POLL: I UTILIZE NON-PHARMACOLOGICAL TREATMENTS & NON-OPIOID MEDICATIONS FOR TREATING PAIN CONDITIONS BEFORE PRESCRIBING OPIOIDS:

### Poll Responses:

1. Always
  - 68% (395 votes)
2. Sometimes
  - 20% (114 votes)
3. Never
  - 0% (2 votes)
4. N/A
  - 12% (67 votes)

## CONSIDER PAIN AND FUNCTIONING SEVERITY

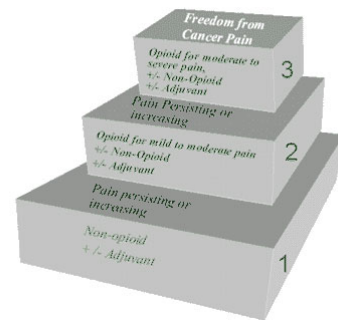
### Decide whether to use opioids based on pain severity and patient functioning

Chronic non-cancer pain should be severe and adversely impacting quality of life or ability to function<sup>9</sup> [Strong recommendation, low-quality evidence]. The World Health Organization's "Pain Relief Ladder," originally developed for treating cancer pain, advocates using stronger opioids with greater pain<sup>21</sup>.

### WHO Pain Relief Ladder Adapted for Non-Cancer Pain

Historically, the three-step "Pain Relief Ladder" was developed in 1986 for cancer pain<sup>21</sup>; it has since been applied to all types of chronic pain. In the original ladder, the World Health Organization recommended prompt, progressively strong pharmacological treatment for chronic cancer pain until there is adequate pain control. Drugs should be administered on a schedule rather than "as-needed." One difference between cancer pain and non-cancer pain is that for many forms of non-cancer pain, non-opioid medications and non-pharmacological treatments are more often the first-line therapy than opioids. The following ladder has been modified slightly for non-cancer pain to reflect practice guidelines<sup>9</sup> recommend opioid use only for moderate or severe non-cancer pain.

WHO's Pain Relief Ladder



1. **Mild pain:** Non opioid, +/- Adjuvant
2. **Moderate pain:** Opioid, +/- Non opioid, +/- Adjuvant
3. **Severe pain:** Opioid, +/- Non opioid, +/- Adjuvant

### Examples of Each Type of Pharmacotherapy

1. **Non-opioid:** Examples: acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs)
2. **Opioid for moderate pain:** Examples: tramadol, codeine, dihydrocodeine, hydrocodone
3. **Opioid for moderate to severe pain:** Examples: morphine, fentanyl, buprenorphine, oxycodone, hydromorphone, tapentadol

\*Note: Extended release/long acting forms of opioids are only for pain "severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate"<sup>20</sup>

4. **Adjuvant:** Examples: antidepressants, anticonvulsants, steroids, muscle relaxants, exercise, psychological counseling, hydrotherapy, acupuncture, topical lidocaine, topical NSAIDs, capsaicin, etc.

\*Consider increased cardiovascular/cerebrovascular and gastrointestinal risk vs. benefits when prescribing NSAIDs<sup>22</sup>.

### Role of Other Pain Therapies

This ladder was developed before nerve blocks, intrathecal therapies, and neuroaugmentation were available worldwide, and so it does not address their proper place in pain therapy.

## MR. LEWIS - PRESCRIBE OPIOIDS?

Recall the following case introduced in another module:



**Patient:** Mr. Raymond Lewis, a 72 y/o male with pain from diabetic neuropathy

**Scenario (repeated for convenience):** Mr. Lewis's medical history is significant for onset of type 2 diabetes at 48 y/o. He has been insulin dependent for 7 years, and his diabetic peripheral neuropathy started with gradual onset of numbness, tingling, and then pain in his feet about 4 years ago. The neuropathy is now constant and mild to moderate during the day, but moderate to severe at night

despite all evidence-based, non-opioid, first- and second-line treatments of tricyclic antidepressants and anti-epileptic drugs.

**Question:** Given what you know about Mr. Lewis's history, should he be prescribed opioids?

1. No, first line treatment should be prescribed.
  - Feedback: Incorrect. First line treatments had already been prescribed and they were ineffective, so now is the correct time to prescribe opioids if they are indicated for the condition and the pain is moderate to severe. Other treatments, such as non-opioid pain medications, adjunctive medications, and non-opioid are still indicated as well.
2. Yes, because first line treatments were ineffective, opioids should be considered.
  - Feedback: Correct. Since first line treatments were ineffective and his pain is moderately severe, opioids may now be prescribed, if they are indicated for the condition and the pain is moderate to severe. However, other treatments, such as non-opioid pain medications, adjunctive medications, and non-opioid.
3. No, Mr. Lewis's pain is not severe enough for opioids.
  - Feedback: Partially correct. His pain is moderately severe, which is severe enough to warrant opioids, especially since first line treatments were ineffective at managing his pain. However, some experts recommend opioids only be used for severe pain. Additionally, other treatments, such as non-opioid pain medications, adjunctive medications, and non-opioid.

## MR. MORRIS - PRESCRIBE OPIOIDS?

### **Patient: Mr. Keith Morris, 55 y/o**

**Case:** Mr. Morris has moderate to severe left shoulder pain, resulting from a previous car accident. First-line therapies have already been tried, and were unsuccessful, so you have decided to start him on chronic opioid therapy to help manage his pain.

**Question:** Would you prescribe opioids alone, or would you combine them with other medications or treatments?

1. Prescribe opioids and other pain medications. Not the best answer.
2. Prescribe opioids, other pain medications, and strenuous exercise. Not the best answer.
3. Prescribe opioids alone. Not the best answer.
4. **Prescribe opioids, other pain medication, and light exercise. Best choice**
  - Feedback: While opioids alone may help manage Mr. Morris' pain, a multimodal treatment plan including adjuvant medications and non-pharmacological treatments such as exercise and counseling is likely to be more effective than opioids alone and minimize Mr. Morris' necessary dosage.

## OPIOID PRESCRIBING GUIDELINES

### **CDC Guidelines for Prescribing Opioids**

The CDC produced the following set of clinical guidelines for all patients based on a review of the evidence and expert input<sup>23</sup>.

1. **Use other treatments first if possible:** Non-opioid pharmacologic medication and nonpharmacologic therapy are preferred treatment for chronic pain. Only consider opioids if benefits for *both pain and functioning* are likely to outweigh risks. If opioids are prescribed, minimize their use by combining with non-opioids and non-pharmacological therapy. Evidence level 3.
2. **Use treatment goals:** Set realistic treatment goals for pain and function at the outset. Explain that treatment will continue only if the risk-benefit ratio is favorable with "clinically meaningful improvement." Evidence level 4.
3. **Discuss risks with patient:** Discuss known risks and realistic benefits of opioid therapy before starting. Define patient and clinician responsibilities for managing therapy. Evidence level 3.
4. **Use immediate release, not extended-release/long-acting (ER/LA) opioids** when starting opioid therapy for chronic pain. Evidence level 4. Note that REMS for ER/LA opioids require that the companies provide special training for prescribers of ER/LA opioids.
5. **Use lowest possible dose:** Reassess benefits vs risks carefully when considering a dosage increase to  $\geq 50$  morphine milligram equivalents (MME)/day. Avoid increasing the dose to  $\geq 90$  MME/day or carefully justify. Evidence level 3.

6. **Prescribe only a 3 day supply for most acute pain, rarely more than 7 day supply:** The supply should be only for the duration of pain requiring opioids, not the duration of the pain. Prescribe the lowest effective dose of immediate-release opioids. Evidence level 4.
7. **Evaluation of benefits vs. harm is ongoing:** Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy or a dose increase. Reevaluate at least every 3 months. Taper to a lower dosage or discontinue opioids if benefits do not exceed harm. Evidence level 4.
8. **Ongoing evaluation for risk of opioid-related harm:** In addition to evaluating to opioid-related harm, plan strategies to mitigate risk, overdose (consider offering naloxone) when factors that increase risk for opioid overdose are present (e.g., history of overdose, history of substance use disorder, higher opioid dosages ( $\geq 50$  MME/day), or concurrent benzodiazepine use). Evidence level 4.
9. **Consult prescription drug monitoring database before prescribing and during treatment:** Look at total opioid doses and dangerous drug combinations. Check database at least every 3 months and consider checking at every prescription. Evidence level 4.
10. **Use urine drug testing before and during treatment:** Test prior to prescribing and at least annually for the prescribed medications, controlled prescription drugs, and illicit drugs. This recommendation that may vary depending on the individual clinician/clinic and/or patient situation. Evidence level 4
11. **Avoid prescribing opioids together with benzodiazepines:** Avoid concurrent prescribing whenever possible. Evidence level 3
12. **Treat opioid use disorder:** Treat or arrange treatment for opioid use disorder, usually with medication assisted treatment, i.e., buprenorphine or methadone, in combination with behavioral therapy. Evidence level 2.

The last guideline, for the treatment of opioid use disorder, is supported by level 2 evidence which is from clinical trials with limitations or exceptionally strong evidence from observational guidelines. All of the other guidelines only have level 3 evidence which is observational studies or randomized clinical trials with notable limitations or level 4 evidence such as clinical experience or observations or studies with important or major limitations.

### APA Clinical Guidelines for Chronic Opioid Therapy

Clinical guidelines for the use of chronic opioid therapy<sup>9</sup> overlap to a large extent with the above, but do include a few additional guidelines:

1. **Pain should be severe** in order to prescribe opioids
2. **Patient/provider treatment agreements:** Consider use of written agreements that describe responsibilities of both the patient and prescribing provider and the treatment structure that helps prevent addiction, misuse, and diversion. Include patient education on using as directed, safe storage, keeping appointments, etc.
3. **Increase treatment structure for higher risk patients:** For example, more frequent appointments and urine drug testing with higher risk
4. **Plan for stopping opioid treatment before starting:** Describe a plan that includes the conditions under which treatment will be stopped, and a plan for tapering and providing psychosocial supports when stopping.

These guidelines will be described further in the following pages.

## ASSESSING RISKS AND BENEFITS

The prescriber must determine whether the perceived risks of taking the medication is outweighed by the potential benefits received.

In order to apply the skills necessary to effectively prescribe and treat patients with opioids, it is important to understand all components of drug information for these medications. Side effects, contraindications, and patient status all need to be weighed against the selected medications in order to determine whether it would be a good treatment choice in their case.



Once the medication selection is made, it is important to safely and effectively initiate treatment through the use of a sound pain management and functional treatment program.

### Before Considering Opioids

#### If the patient has severe pain that has not responded to first line therapies...

1. Consider that the patient might have a genetic variation that is affecting response to a particular first line medication and try another<sup>24</sup>.
2. Decide whether to use opioid therapy by weighing the risks (including the risks of opioid misuse and the risks of side effects) vs. the potential benefits of chronic opioid therapy.
3. Ensure that the patient understands opioid treatment risks and side effects. This is part of informed consent.

### PRACTICE TIP

Patients must be monitored for any adverse reactions that may occur and their treatment program should be adapted to deal with these issues when they come up. **[A module is dedicated to this important task]**

## POTENTIAL BENEFITS OF CHRONIC OPIOID THERAPY

**1. Decreased pain:** Opioids, in general, are effective for reducing the intensity of moderate to severe non-cancer pain<sup>25</sup>. However, they are the second or third line of therapy for most common chronic pain conditions.

- Pain decrease is likely to be a few points on a scale of one to ten<sup>9</sup>, as with many other analgesics.
- ER/LA opioids are recommended for use with constant, chronic pain (intense pain is experienced over half the time), because they can provide longer and more consistent plasma concentration of the drug compared to short-acting versions<sup>26</sup>. This might also lead to fewer episodes of breakthrough pain caused by the end of a dose<sup>26</sup>.
- Constant plasma levels might also be less addicting, due to the more stable blood levels not producing intermittent, reinforcing peaks in dosage.



*Note: ER/LA opioids are not recommended to manage uncontrolled pain. Use an immediate release formulation until pain is controlled and then convert to the same opioid in an ER/LA formulation.*

**2. Improved sleep:** The ER/LA opioids are effective for consistently controlling night pain due to not needing to awaken to take another dose<sup>26</sup>.

**3. Improved function:** Opioids may provide some improvement in functioning and help restore some quality of life for patients in chronic non-cancer pain<sup>27</sup>.

- ER/LA opioids offer the advantage that they may be more easily scheduled so that the person can better function upon arising in the morning.

## CONSIDER THE EVIDENCE

### **What is the Evidence Regarding Chronic Opioid Therapy?**

**Research evidence for use of chronic opioid therapy is weak in general, but chronic opioid therapy appears to be effective for some individuals.**

A review of the evidence by the American Society of the Interventional Pain Physicians (ASIPP), found "weak" support for the use of chronic opioid therapy in the treatment of chronic, noncancer pain<sup>28</sup>. The weakness of the recommendation was due to:

1. variability in effectiveness
2. relatively high risks and burdens
3. few long term clinical studies

**Effectiveness.** However, opioids are effective for some individuals due to variation in response, so chronic opioid therapy should be viewed as an individual trial. The response to opioids is typically a few points on a scale of 1 to 10<sup>29</sup>. This is also true for many other analgesics.

**More research is needed.** Gaps in the evidence for chronic opioid therapy include a need for studies of the following<sup>30</sup>:

- optimal performance of risk assessments
- optimal dosing strategies and effects of higher dosage treatment
- initiation and titration
- long term risks/benefits
- opioid rotation
- efficacy of treatment agreements and informed consent
- chronic opioid therapy in "special populations" (pregnant women, children, etc).

## EVIDENCE FOR CHRONIC OPIOIDS FOR SPECIFIC CONDITIONS

The strength of the evidence for opioid use varies with the underlying condition. For many pain conditions, opioids are second or third-line drugs used only after other treatment options have been unsuccessful.

- *Chronic low back pain.* There is moderate quality evidence that strong, long-acting opioids, such as morphine and oxycodone, are more effective than placebo at short-term decreases in pain and improvements in function<sup>31</sup>.
- *Poorly-defined pain conditions and somatoform disorders.* The presence of a poorly defined

- pain condition or a somatoform disorder predicts an unfavorable response to opioid therapy<sup>32</sup>.
- *Conditions with strong psychosocial components.* Chronic pain is understood to be multifactorial in nature. Therefore, nonpharmacological methods, such as behavior therapy and physical rehabilitation, are often implemented along with pain medications<sup>33</sup>.
- *Neuropathic pain.* Use of opioids to treat neuropathic pain remains controversial. However, low-to-moderate doses of opioids administered over a period of weeks to months have been shown in studies to decrease multiple forms of neuropathic pain<sup>34</sup>.
- *Cancer pain.* The World Health Organization reports that their three-step approach to treating cancer pain, the "WHO Pain Relief Ladder", which recommends specific classes of progressively stronger pain medications until there is relief (right drug, right dose, right time), is effective 80 to 90% of the time for cancer pain<sup>21</sup>. Opioid analgesics, nonopioid analgesics, and adjuvant analgesics are all used to treat cancer pain<sup>35</sup>.

## RISKS OF OPIOID THERAPY

### Understanding the Risks of Opioid Therapy

Beginning chronic opioid therapy with patients has several risks. It is important that the provider be aware of these risks and weight them against the benefits before prescribing. When contemplating chronic opioid therapy, assess all patients for

- Current opioid misuse
- Addiction



### Risks of chronic opioid therapy include:

- Addiction, abuse and misuse
- Unintentional diversion. Make sure to warn patients that opioid analgesics must be protected from theft.
- Overdose: accidental or intentional. In 2009, there were over 15,500 deaths resulting from prescription painkiller overdose. More than 30% of the prescription painkiller deaths involved methadone<sup>36</sup>.
- Accidental use of opioids
- Interaction with other medications and substances

*Tolerance* is considered the decrease of pain relief with the same dosage over time. Tolerance has not been shown to be a barrier to long-term opioid use. If a non-cancer patient fails to respond to increasing doses of the opioid they should be evaluated for tolerance, disease progression, non-opioid responsive pain syndromes, and opioid -induced hyperalgesia<sup>37</sup>.

- Physical dependence can occur as a result of the body becoming used to regular use of a medication.
- Withdrawal can be a result of physical dependence (NPF, 2009).
- Individual genetic variations can contribute to increased risk for respiratory depression (morphine, codeine) cardiac arrhythmia (methadone) and so a family history of adverse reactions may be relevant<sup>24</sup>. Pharmacogenomic testing may be able to ascertain whether a particular patient carries the responsible gene or genetic abnormality. This is a relatively new field in terms of being used clinically and may expand further in the future. For example, medications that are more likely to be both effective and safe may some day be selected according to the patient's genetic profile.



## ASSESSING RISK WITH STRUCTURED TOOLS

Questions about risk can be part of the medical history or presented in questionnaires, such as the Opioid Risk Tool<sup>38</sup>. The Opioid Risk Tool<sup>38</sup> asks about:

- age
- family and personal history of substance use disorder
- history of preadolescent sexual abuse (correlates for females)
- presence of mental health problems, such as ADHD, OCD, bipolar disorder, schizophrenia, and depression

Evidence for the effectiveness of using this tool has been inconsistent<sup>1</sup>.

Questionnaires that screen for addiction, for example, the CAGE-AID<sup>39</sup> are also useful. Responses help determine whether opioids can be used safely and how to structure an opioid treatment plan that minimizes risk of long-term dependence and other substance use problems<sup>9</sup>.

### Case Example



**Patient:** Mr. Raymond Lewis, 72 y/o

**Scenario:** Given Mr. Lewis's history of past heroin addiction and depression, his risk is increased for substance use disorder and overdose if he has chronic opioid therapy. However, given that it has been many years since his heroin addiction and several years since an episode of depression, the risk is less than if these were current problems.

## CONDITIONS INCREASING RISKS FROM OPIOIDS

Patients being considered for an opioid prescription or who are already being treated with opioids should be evaluated periodically for the following conditions that increase the risk of harm from opioids<sup>1</sup>:

- Sleep apnea
- Pregnancy
- Renal or hepatic insufficiency
- Age 65 or older
- Substance use disorder
- Mental health problems, including anxiety, PTSD, and/or depression, psychiatric instability, and/or suicide risk
- Elevated risk for overdose including:
  - history of overdose
  - history of substance use disorder
  - relatively high opioid dose ( $\geq 50$  MME\*/day)
  - concurrent benzodiazepine use



If opioid use cannot be avoided, a management plan should include plans to offset any risk including offering naloxone for use in the event of an overdose.

\*MME = morphine milligram equivalent

## ADDICTION AND MISUSE

### **Addiction**

*Addiction* is a risk for patients who are on opioids for chronic pain. The term "addiction" includes one or more of the following:

- impaired control over drug use
- compulsive use
- continued use despite negative consequences
- cravings for opioids

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The rate of developing opioid addiction among those taking opioids for chronic pain was estimated to be 8% - 12%<sup>40</sup>. However, these figures do not account for those who experience opioid dependence or withdrawal.



### **Misuse**

In 2012, an estimated 22.4 percent of young adults had used pain relievers nonmedically at some point in their lifetime<sup>4</sup>.

Opioids may be misused to get "high", to self-medicate, to improve one's mood (chemical coping/self-medicating for depression), or to divert to other people. Opioid use disorders or other substance use disorders affect 19 to 35% of patients on chronic opioid therapy<sup>41,42</sup>.

## HOW COMMON IS SUBSTANCE USE DISORDER AND RELATED PROBLEMS?

### **Addiction and Abuse vs. Physical Dependence and Tolerance**

Mild forms of the diagnosis "Substance use disorder" are more common than severe forms.

Note that the terms addiction, physical dependence, tolerance, and substance abuse are descriptions and are not official diagnoses.

### **Frequency of Addiction, Substance Use Disorder, and Physical Dependence**

1. Physical dependence is common in patients on chronic opioid therapy.
2. Abuse/addiction is much less common than physical dependence.
3. Addiction is less common than other forms of abuse<sup>43</sup>

The abuse/addiction rate for all chronic pain patients in an analysis may be as high as 35%. One summary of 67 studies found the rate of addiction was 3.27%, and of aberrant drug-related behaviors was 11.5%<sup>41</sup>. However, more recent study found the rate of "opioid use disorder" to be around 35% whether DSM 4 or 5 criteria were used<sup>42</sup>. One reason for the increase may be that the proportion of opioids prescribed for non-cancer pain has increased and the rate of opioid prescribing has increased. The actual percentages are somewhat uncertain due to few prospective studies<sup>43</sup>. Rates are relatively low among persons who do not have current substance abuse or a history of substance abuse: less than 1% for abuse/addiction and 0.6% for aberrant drug-related behavior, according to a meta-analysis of 67 studies<sup>41</sup>. The risk is higher when there is prior or current abuse of another substance.

## PRACTICE TIP

Because physical dependence is so common in chronic opioid therapy, it can be thought of as being similar to a chronic illness that can be managed, like diabetes.

Who would prescribe insulin for a diabetic and not schedule regular follow-up?

## OVERDOSE

### Epidemiology

Lethal overdose is at epidemic levels. Overdose from prescription drugs is an epidemic, according to the CDC: 33,091 died from opioid overdose in 2015, which is up 16% from 2014<sup>44</sup>. The increase is largely due to an increase in heroin and synthetic opioids other than methadone. A doubling in poisoning deaths from 1999 to 2006 was largely due to an increase in deaths from prescription opioids and corresponded to an increase in opioid prescribing for pain over the same period<sup>45</sup>.

Methadone is a common cause; more than 30% of the prescription painkiller deaths involved methadone<sup>36</sup>. In 2015 methadone overdose deaths declined 9.1%<sup>44</sup>.

### Overdose Risks

Overdose is more likely with the following:

- a history of substance use disorder
- sleep apnea (Note that chronic opioid use itself may induce sleep irregularities or sleep apnea, even in individuals who do not have elevated BMI<sup>46</sup>)
- depression
- concurrent sedative-hypnotic medications
- new prescriptions or refills
- high doses
- extended release/long acting opioids
- methadone being used for pain treatment

<sup>47,48</sup>

Consider taking a preventive approach, for example, a patient being treated with benzodiazepine for anxiety might be switched to an SSRI, which can be effective in the treatment of anxiety<sup>49</sup>.

### Respiratory depression

Respiratory depression and central nervous system depression are important symptoms to manage in opioid overdose. Use the opioid antagonist naloxone with clinically significant respiratory depression or circulatory depression<sup>50,51</sup>.

Supportive measures include the ABC's (airway, breathing, circulation) plus naloxone as an antidote<sup>50</sup>. Ventilation should be with 100% oxygen prior to the naloxone<sup>51</sup>. Naloxone is continued until spontaneous ventilation returns.

### Special considerations for Extended Release/Long Acting (ER/LA) opioids

The ER/LA opioids action may extend beyond the effect of the antidote, so it is important to continue to carefully monitor the patient for 24 to 48 hours after the overdose<sup>52</sup>.

Overdose risk is greater with ER/LA opioids due to the dosage units containing more opioid than IR formulas. Opioid overdose can cause respiratory suppression, leading to cardiac arrest.

### CAUTION TIP

SAMHSA Opioid Overdose Prevention Toolkit (2014) recommends considering prescribing naloxone along with the patient's initial opioid prescription.

## RESPIRATORY DEPRESSION

### Warning Signs and Symptoms of Respiratory Depression

**Respiratory depression is immediately life threatening!**

When starting treatment with an opioid naive patient, be sure to monitor their sedation level and respiratory status regularly, especially in the first 24 hours. Start with a low dose, titrate, and monitor<sup>50</sup>.

Respiratory depression and central nervous system depression are important symptoms to manage in opioid overdose. Opioids, including ER/LA opioids, can reduce the breathing rate (bradypnoea), delay exhalation, and produce irregular breathing. Sedation is another warning sign of respiratory depression, but patients may appear asymptomatic initially<sup>53–55</sup>. Naloxone may be used to treat severe opioid-induced respiratory depression<sup>56</sup>. Use a respiratory monitoring device, such as a CO<sub>2</sub>/SpO<sub>2</sub> monitor<sup>57</sup> if available, to confirm respiratory depression and to monitor response to naloxone.

There is no single definition of respiratory depression. Respiratory depression can be defined as an insufficient response to hypercapnia or to hypoxia that results in a lowered rate of respiration or decreased minute ventilation. Respiratory depression can also be defined as a decrease in respiratory rate, pulse oximetry value, or carbon dioxide tension to a level that is lower than an arbitrary threshold<sup>58</sup>. Respiratory rates considered depressed range from <8 to 10 breaths/minute. Another indication of inadequate ventilation is decreased oxygen saturation with pulse oximetry (SpO<sub>2</sub> levels <90%)<sup>54</sup>.



## INCREASED RISK FOR RESPIRATORY DEPRESSION

Patients with the following characteristics are at increased risk for opioid induced respiratory depression:

- Age - over 55 yo
- Smoker
- Dependent functional status (cannot walk 4 blocks or climb 2 sets of stairs, assisted ambulation)
- **Sleep related**
  - Obstructive sleep apnea, untreated
  - Snoring or witnessed sleep apnea
  - Excessive Daytime sleepiness

- **Physical characteristics**
  - Retrognathia
  - Large neck circumference (>17.5")
  - Obesity - BMI  $\geq$  30kg/m<sup>2</sup>
- **Systems**
  - Pulmonary/cardiac disease or dysfunction (e.g. COPD, CHF)
  - Major organ failure
- **Related to pain management**
  - 1st 24 hours of opioid therapy
  - Increased opioid dose requirement
  - Pain is controlled after a long period of poor control
  - Large single-bolus techniques
  - Continuous opioid infusion in opioid-naive patients
- **Medication interactions and additive effects**
  - Simultaneous use of sedating agents, e.g., benzodiazepines or antihistamines
  - Recent use of naloxone for respiratory depression - risk for repeated respiratory depression
- **Risks related to surgery**
  - High anesthesia risk
  - Prolonged surgery (>2 hrs), incisions interfering with adequate ventilation

<sup>54</sup> image courtesy Wellcome Images

## TREATMENT OF RESPIRATORY DEPRESSION

Supportive measures include the ABC's (airway, breathing, circulation) plus naloxone as an antidote is indicated<sup>50</sup>. Ventilation should be started with 100% oxygen prior to the naloxone<sup>51</sup>. Monitor patients with respiratory rates > 10 breaths/minute carefully, with respiratory monitoring if available.

To reverse clinically significant respiratory depression, use the opioid antagonist naloxone (also used to reverse circulatory depression)<sup>50,51</sup>. Titrate naloxone to effect and continue infusion until chances for re-narcotization are reduced. The dose needed varies with the opioid being reversed, for example, opioids with high receptor affinity will require greater concentration of naloxone<sup>59</sup>.

Recommendations for naloxone treatment, for adults, are as follows:

1. Start with 0.4 mg 2 mg naloxone (NARCAN) intravenously (or intramuscular or subcutaneous if intravenous is not available). If respiratory function has not improved sufficiently, repeat at 2 to 3-minute intervals up to a total dose of 10 mg<sup>60</sup>. Note: The naloxone injection usp solution is supplied in 1 mg/ml concentration<sup>60</sup>.
2. If there has been no response, re-evaluate the diagnosis of opioid toxicity or partial opioid toxicity<sup>60</sup>. Respirations should be mechanically assisted and other resuscitative measures used if clinically indicated.
3. Because the duration of naloxone is relatively short, continue to monitor the patient. Additional doses may be needed when the naloxone effect wears off. This varies with the amount of

opioid taken and whether it was long-acting/extended release<sup>60</sup>.

4. If respiratory depression is prolonged and continued boluses of naloxone are needed, continuous IV infusion of naloxone should be considered<sup>61</sup>.

### Special considerations for long acting/extended release opioids

Consider that the antidote might trigger an acute withdrawal in an opioid-dependent patient<sup>52</sup>. Nausea and vomiting with a risk for pulmonary aspiration may be part of the acute withdrawal. The long acting/extended release opioids action may extend beyond the effect of the antidote, so it is important to continue to carefully monitor the patient for 24 to 48 hours after the overdose<sup>52</sup>.

## NALOXONE OVERDOSE PREVENTION KIT

Naloxone kits are used for the reversal of a narcotic overdose, induced by opioids. The following kits are currently available:

- Single-dose hand-held, auto-injector systems (FDA approved in 2014)
- Muscle syringes. One syringe per 1ml of naloxone (FDA approved)
- Intranasal spray. (Narcan® intranasal spray received FDA approval as of November 2015).



Injectable dosages for intravenous, intramuscular and subcutaneous administration include:

- 1 mg/ml
- 10 ml (multi-dose)

Candidates for naloxone may include patients who are:

- Taking high doses of opioid medication for the prolonged management of chronic pain/illness
- At risk for incomplete cross-tolerance
- Taking extended-release opioid preparations that may pose a risk for overdose
- At risk for overdose due to medically prescribed analgesia, combined with a suspected or confirmed history of substance misuse, or dependence

### PRACTICE TIPS

Consider giving the patient naloxone for use in the event of an overdose, especially when risk for opioid overdose is elevated, for example, with a history of overdose or substance use disorder, with higher opioid dosages ( $\geq 50$  MME/day), or with benzodiazepine use<sup>1</sup>.

Naloxone kits can be distributed to family members, friends, peers, employers, non-medical staff/ volunteers, and also to the at-risk patient.

## OPIOID DEPENDENCE AND TOLERANCE

Tolerance refers to a decrease in the drug's effects such that ever-increasing doses of the drug are required to produce the same effect<sup>62</sup>. As the term applies to opioids, tolerance may refer to 1) the analgesic effects of the medication, 2) the side effects of opioids such as respiratory depression, nausea, and sedation, or 3) opioid-induced constipation<sup>63</sup>. All patients on opioid medications can potentially develop a physical dependence on the medications<sup>62</sup>.

Once an individual has developed a physical dependence, cessation of opioid administration will lead to the onset of physical withdrawal. It



is normal to develop physiological dependence on chronic opioid therapy; it becomes an addictive disorder when it disrupts the individual's life as described below.

It is important to note that the diagnosis of **Opioid Use Disorder** (formerly either the diagnosis of **opioid abuse** or **opioid dependence** in the DSM-IV) are different from **physiological opioid dependence**. Simple physiological dependence is normal and occurs in nearly everyone who receives chronic opioid therapy.

## OPIOID WITHDRAWAL

Withdrawal, classified as a substance-induced disorder by the DSM, is a pattern of physiological, psychological, and behavioral changes precipitated by the decline in an individual's bodily levels of a substance. It is usually seen when the individual has a fairly consistent history of use<sup>64</sup>. In the case of opioids, this occurs when an individual suddenly ceases or substantially decreases opioid use<sup>65</sup>.

When individuals who are dependent on opioids experience a drop in opioid levels, they go into a dysphoric state of **withdrawal**. Opioid withdrawal is characterized by:

- drug craving
- anxiety
- yawning
- sweating
- lacrimation
- rhinorrhea
- mydriasis
- gooseflesh
- spasms
- insomnia
- hypertension
- abdominal cramps
- vomiting
- diarrhea
- muscle and joint pain



65,66

While extremely uncomfortable, opioid withdrawal is not typically life-threatening.

An instrument commonly used to gauge opioid withdrawal symptoms is the Clinical Opioid Withdrawal Scale (see sidebar). The COWS classifies patients, based on their symptoms, as being in either mild, moderate, moderately severe, or severe withdrawal.

## DSM CRITERIA FOR OPIOID WITHDRAWAL

A. **Either** of the following:

1. cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
2. administration of an opioid antagonist after a period of opioid use

B. **Three (or more)** of the following, developing within minutes to several days after Criterion A:

1. dysphoric mood
2. nausea or vomiting
3. muscle aches
4. lacrimation or rhinorrhea
5. pupillary dilation, piloerection, or sweating
6. diarrhea
7. yawning
8. fever
9. insomnia

C. Criterion B symptoms are responsible for "clinically significant distress" or "impairment in social, occupational, or other important areas of functioning."

D. This criterion excludes symptoms due to a general medical condition that are better explained by another mental disorder.

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## OPIOID USE DISORDER

The following chart outlines the criteria that are needed for a diagnosis of Opioid Use Disorder, according to the DSM 5, which was published in May 2013. To obtain this diagnosis, you must have at least 2 criteria. Severity is determined as follows: 0-1 criteria is no diagnosis, 2-3 is mild, 4-5 is moderate, and 6 or more is severe. Note: The list below combines the DSM-IV TR criteria for Opioid Abuse and Opioid Dependence. Another change is that cravings were added as a criterion and legal problems were removed as a criterion.

- Continuing to use opioids despite negative personal consequences
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount
- Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal
- Using greater amounts or using over a longer time period than intended
- Persistent desire or unsuccessful efforts to cut down or control opioid use
- Spending a lot of time obtaining, using, or recovering from using opioids
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- Craving or a strong desire to use opioids (\*Note - This is a new criterion added since the DSM-IV-TR)

In the DSM 5, published in 2013, normal physiological dependence that everyone experiences if on chronic opioid therapy is excluded from the criteria for the diagnosis of substance use disorder<sup>64</sup>.



Other modifications of the Substance Use Disorder that can be added include: "in early remission," "in sustained remission," "on maintenance therapy," and "in a controlled environment."

## POTENTIAL SIDE EFFECTS OF CHRONIC OPIOID THERAPY

### Common opioid side effects

Providers should periodically assess benefits and side effects of ER/LA opioid analgesics on their patients, and the continued need for them.

Side effects vary with: the opioid and dose, race, gender, and age

- constipation (40 to 95%)
- sedation – especially with new prescriptions or dose increases
- nausea
- endocrine effects with long term use, e.g., hypogonadism, decreased libido, erectile dysfunction
- sleep disorders and sleep apnea, even at relatively lower BMI
- physical dependence - continued doses required to avoid withdrawal symptoms
- tolerance - a higher dose needed to achieve similar effects.



9,28,46

Adverse side effects lead around 20% of patients to discontinue opioids<sup>67</sup>. Side effects vary with:

- the opioid and dose
- race
- gender
- age

Plan for common side effects to prevent their impact. For example, constipation, a very common side effect, can be prevented through use of a stool softener. Instruct patients to call their prescriber for information about managing side effects.

### Pre-existing conditions that increase side effects:

- Constipation
- Nausea
- Pulmonary disease
- Cognitive impairment
- Substance abuse
- Advanced age and; Risks in the elderly include increased risk of pneumonia<sup>68</sup>

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## CASE EXAMPLE: RAYMOND LEWIS AND SIDE EFFECTS



**Patient:** Mr. Raymond Lewis, 76 y/o

**Scenario:** Mr. Lewis does not report any current or recent problems with constipation or nausea. Nor does he have any history of pulmonary disease. His doctor administers a mini-mental status exam (MMSE) to check for cognitive impairment and asks if he has had any memory problems. Mr. Lewis

scores 28/30 (in the normal, non-impaired range) on the MMSE and reports only having a little more trouble remembering names as he gets older but no other problem with his memory.

There is nothing to suggest that Mr. Lewis would experience more or more severe side effects from opioids than normal. Because constipation is so common, the doctor prescribes a stool softener and counsels Raymond on how to prevent constipation. His doctor will avoid higher opioid doses because Mr. Lewis is 76 and there is increased risk of pneumonia with age.

## MR. LEWIS - CHRONIC OPIOID THERAPY

**Patient:** Mr. Raymond Lewis, 72 y/o

**Scenario:** Mr. Lewis has diabetic neuropathy in his foot, has 2 risk factors for opioid misuse: history of heroin addiction and history of being treated for depression. He has no known risk factors to increase the side effects of opioids beyond what most people experience.

**Question:** Given the risks and the likely benefits, should chronic opioid therapy be considered for Mr. Lewis?

1. Yes. No additional precautions needed.
  - Feedback: Incorrect. Because Mr. Lewis has at least two risk factors for opioid misuse, additional precautions need to be used, such as more frequent appointments, all spelled out in the Patient/Provider Treatment Agreement.
2. Additional precautions needed if opioids prescribed.
  - Feedback: Correct. Additional precautions are needed beyond those used for people with little or no risk of opioid misuse. Because Mr. Lewis has at least two risk factors for opioid misuse, additional precautions need to be used, such as more frequent appointments, all spelled out in the Patient/Provider Treatment Agreement. Additionally, he should be screened for depression prior to prescribing and periodically during treatment. If he does have depression, this problem should be treated.
3. No, opioids may not be prescribed even with extra precautions.
  - Feedback: Incorrect. Despite Mr. Lewis having at least two risk factors for opioid misuse, he can be prescribed opioids if they are indicated if additional precautions are used, such as more frequent appointments, all spelled out in the Patient/Provider Treatment Agreement.

## MR. PATTERSON - RECOMMENDATIONS

**Patient:** Mr. Gary Patterson, 70 y/o

**Scenario:** Mr. Patterson has gradually increasing pain from hip bursitis. Despite trying first line treatments, the pain is now severe and nearly constant when unmedicated. The pain is worse with a lot of activity, and as an avid golfer, Mr. Patterson is disappointed that he often cannot play. Hip replacement has been discussed, but Mr. Patterson refuses surgery. Mr. Patterson takes an immediate release opioid regularly, which reduces the pain only from an 8 out of 10 down to a 6 or 7 out of 10. The peak analgesic effect is brief and there are constant periods with insufficient pain relief. He wakes in the middle of the night needing another dose. He wants better, more constant pain relief and to be able to sleep through the night.

**Question:** Of the following, which of the following is appropriate recommendation for Mr. Patterson? (Choose all that apply:)

1. Recommend limiting physical activity during acute flare-ups of his bursitis
  - Feedback: Correct. While most people figure out that limiting their activity when their bursitis or arthritis has flared up, some people may need to be told to avoid physical activity during severe, acute flare-ups. It is important that Mr. Patterson get regular exercise to strengthen the muscles around the joint in order to provide support.

2. Consider prescribing an extended-release/long-acting opioid taken on a regular schedule
  - Feedback: Potentially correct. After pain control is achieved by increasing the dose of immediate release opioid, Mr. Patterson could be switched to a long acting formula of the same opioid due to his pain being constant and severe. Consistent plasma concentrations might reduce his experience of "flare-ups." This could also help improve his sleep. Other pain treatments should be included to spare the opioid dose.

Note: Buprenorphine is the most recommended ER/LA opioid for older populations. Be sure to consider cognitive ability when prescribing opioids. Does the patient need a caregiver involved in daily administration of medications? ERLA opioids should only be used if absolutely necessary to obtain pain control.
3. Keep Mr. Patterson on his short acting, immediate release opioid and increase the dosage.
  - Feedback: Correct. This is a possible response in the short-term in order to achieve pain control. Switching Mr. Patterson to the long-acting formula of the same opioid once his dose is stable is another possibility. Other pain treatments should be included to spare the opioid dose.
4. Add adjunctive medications to spare the opioid dose needed.
  - Feedback: Correct. Adding adjunctive medications and non-pharmacological treatments is a good option to improve pain management and reduce opioid dose.

## ASSESSING RISK FOR OPIOID USE DISORDER

### Stratification by Risk

"Stratification by risk" means assigning a level of care including practice setting and structure and intensity of monitoring based on the amount of risk. All patients need a basic level of pain management structure and monitoring or "universal precautions" originally set by Gourlay et al. 2005, but patients at high risk need more structure:

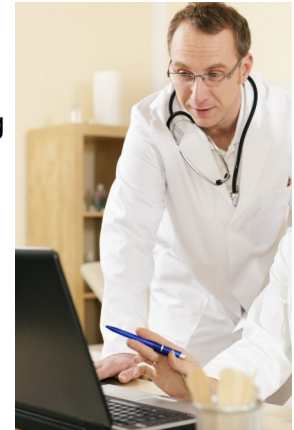
<b>Low Risk:</b>	Can be managed in primary care and monitored once every three to six months after the opioid dose is stable.
<b>Moderate Risk:</b>	Consultations and referrals to specialists followed by co-management between primary care and the specialists and in-person monitoring monthly or more often is needed.
<b>High Risk:</b>	Should be referred to pain/addiction specialists and have more frequent monitoring, often weekly or even more often as needed.

### Responding to Moderate or High Risk

Patients with higher risk will require a higher level of treatment structure potentially including the following precautions:

- Urine drug-screening (although some experts recommend this for all patients)

- A written "Patient/Provider Treatment Agreement" defining expectations of both healthcare provider and patient (although some experts recommend this for all patients)
- Increased monitoring of medication use, such as more frequent checking of Prescription Drug Monitoring programs, at least every 3 months for all patients, consider checking at each prescription<sup>1</sup> and more frequent pill counts (have patient bring in bottle)
- Discussion of alternative treatment
- Further assessment
- Referral to a specialist



**Despite risk, all patients with pain deserve to be treated.**

## MR. LEWIS - SCREENING RESULTS

### **Risk Summary:**



**Patient:** Mr. Raymond Lewis, 72 y/o

**Scenario:** Mr. Lewis revealed that he had a history of heroin addiction in his young adulthood treated with methadone until 20 years ago. Since then his only substance use has been 2-3 drinks of alcohol per week. He has a history of being treated for depression several times, but not in recent years. However, he sometimes feels "down" now because of his pain. His family is supportive and neither they nor anyone else with whom he now associates has current or past substance abuse problems. Mr. Lewis works as an insurance claims adjuster and has not had any recent motor vehicle accidents or legal problems. He scored 5 (Moderate Risk) on the Opioid Risk Tool.

Recall, also, that first and second line therapies of tricyclic antidepressants and anti-epileptic drugs have not worked very well in treating Mr. Lewis's moderate to severe pain from diabetic neuropathy.

**Question:** Check all of the following that apply regarding using chronic opioid therapy with Mr. Lewis:

1. A written, signed Patient/Provider Treatment Agreement should be considered
  - Feedback: Correct! A written, signed Patient/Provider Treatment Agreement is indicated, given his two risk factors of history of heroin addiction and depression, although many experts recommend use of a treatment agreement with all patients on chronic opioid therapy.
2. Chronic opioid therapy should not be considered in Mr. Lewis's case due to two risk factors
  - Feedback: Incorrect. The 2 risk factors should be considered, but they do not absolutely preclude use of opioids if his pain is severe enough and has not responded to first line treatments. Mr. Lewis should have his pain treated and if nothing else has worked, opioid therapy may be effective and can be tried with appropriate additional treatment structure, due to his risk factors for opioid misuse. His risk factors should be weighed against potential benefit of taking opioids. His history of heroin addiction is a risk factor suggesting the need for additional precautions even though it was many years ago, although it is not as much of a concern as it would be if it was more recent.

3. Urine drug testing before and during therapy should be considered
  - Feedback: Correct. Urine drug testing before and during therapy is indicated, given his two risk factors of history of heroin addiction and depression, although many experts recommend urine drug testing with all patients on chronic opioid therapy.
4. No additional precautions are needed since his heroin use was so long ago.
  - Feedback: Incorrect. His history of heroin addiction is a risk factor suggesting the need for additional precautions even though it was many years ago, although it is not as much of a concern as it would be if it was more recent. His history of depression is also a risk factor.
5. Consultation(s) with or referral to a specialist(s) who understand both pain and addiction for his pain management, if the provider does not have sufficient expertise in these areas
  - Feedback: Correct. Given the risk involved (at least moderate risk), a provider should feel they have sufficient expertise in both pain and addiction to manage the risk involved or at least consult with specialists as needed or make a referral.

### STRATIFICATION OF RISK

After patient selection for long-term opioid therapy, patients can be triaged into three treatment groups (primary care, primary care with specialist support, specialist referral) based on level of risk for substance misuse (stratification of risk-low, medium, high)<sup>69</sup> as described in the table below. However, keep in mind, the actual risk level of any individual is never known for sure and so a minimum level of caution may be indicated for all patients, as described in the universal precautions for pain medicine described in the first module.

<u>RISK LEVEL</u>	<u>PATIENT CHARACTERISTICS</u>	<u>SETTING OF CARE</u>
<u>LOW RISK</u>	<ul style="list-style-type: none"> <li>• Mild to moderate pain; clear etiology</li> <li>• No history of substance use problem, past or current</li> <li>• No contributory family history of substance misuse</li> <li>• No major or untreated mental health problems; strong self esteem</li> <li>• Good social support</li> <li>• Rich work or avocational life</li> </ul>	Primary Care
<u>MODERATE RISK</u>	<ul style="list-style-type: none"> <li>• Moderate to severe pain with unrelieved stress for many years; uncertain etiology but some suggestions of one</li> <li>• History of substance use problem (treated)</li> <li>• Comorbid minor or past major mental health problem; poor coping skills</li> <li>• Some inadequacy in social support;</li> </ul>	Primary Care Management with Specialist Support, ongoing (that is, "comanagement" or refer as the needs arise to addiction and/or pain specialists)

<u>RISK LEVEL</u>	<u>PATIENT CHARACTERISTICS</u>	<u>SETTING OF CARE</u>
	<p>sometimes lost as a result of many years of pain</p> <ul style="list-style-type: none"> <li>• Only some engagement with meaningful activities</li> <li>• Older adults</li> </ul>	
<u>HIGH RISK</u>	<ul style="list-style-type: none"> <li>• Personal and/or family substance misuse history</li> <li>• Active addiction or current illicit use</li> <li>• Major untreated mental health problem</li> <li>• Isolated, dysfunctional social environment</li> <li>• No satisfying work, recreation, or other activities</li> </ul>	<p>Refer for Specialty Pain Management and/or Specialty Addiction Management.</p> <p>Note: In some cases opioids may not be indicated until the comorbidity is under control. Primary care should monitor specialty care while continuing to manage medical care</p>

Sources: Adapted from Webster, 2005; Savage et al., 2008.

## TREATMENT RESPONSES TO RISK

### **1. Adapt the Structure of Care to Match Risks**

Adapt the following aspects of treatment structure to match the risk level:

- Setting of care (primary care versus specialty care; clinical care team membership);
- Selection of treatment (risk/benefit assessment of specific medications and treatments);
- Supply of medications (controls on and amounts of medications dispensed);
- Supports for recovery (implementation and documentation of recovery activities)
- Supervision and monitoring (frequency of visits, urine toxicology screens, pill counts, other)<sup>43</sup>

### **2. Consult as Needed to Determine Risk**

Consultation with specialists in pain medicine, addiction medicine, and/or counseling may be needed for assistance with assessment or stratification of risk, depending on the expertise of the provider and the complexity of the case. For example, consultation should be considered with a history of addiction, comorbid psychiatric disorder, or other high-risk factor for addiction/substance misuse.

### **3. Refer as Needed**

Determine which type of pain or addiction specialist is appropriate:

1. Consider referring patients who develop a chronic pain syndrome to a pain specialist.
2. Refer patients who have an addiction disorder for addiction treatment.
3. Refer patients to other medical and mental health specialists when appropriate.
4. Refer chronic pain patients who require opioid therapy and have "yellow flags" for addiction to a pain specialist with expertise in addiction or a combination of appropriate specialists.
5. Include all key patient information (history and current status) in referral report.

## RISK ASSESSMENT TOOLS

### **Opioid Risk Assessment**

A number of screening tools specifically screen for risk of opioid misuse in the context of chronic pain treatment. These may be especially helpful in determining relative risk along with the medical history intake forms, patient interview, laboratory results, and physical examination.



More research is needed to determine the extent to which risk assessment tools predict clinical outcomes<sup>9</sup>. Several assessment tools, all in self-report format, appear to have good validity<sup>9</sup>. The CDC's review found that results were inconsistent (for the ORT, ranging from non-informative to moderately useful) or studies assessing these instruments were sparse<sup>1</sup> :

- Opioid Risk Tool (ORT)
- Screener to Predict Opioid Misuse Among Chronic Pain Patients (SOAPP - R)
- Diagnosis, Intractability, Risk, Efficacy (DIRE)
- Current Opioid Misuse Measure (COMM)

The health professional should:

- introduce the instrument to the patient
- explain the reason for its use
- ask the patient to briefly and honestly answer the questions by marking his or her responses.

### ORT: OPIOID RISK TOOL

- **Questions:** The questions asks whether there is
  1. Family history of substance abuse with alcohol (1 female, 3 male), illegal drugs (2 female, 3 male), or prescription drugs (4 female, 4 male)
  2. Personal history of substance abuse with alcohol (3), illegal drugs (4), or prescription drugs (5)
  3. History of preadolescent sexual abuse (3 female, 0 male)
  4. Psychiatric disorder (Depression 1, ADD/OCD/bipolar/schizophrenia 2)
- **Purpose:** Assesses risk of aberrant behaviors when patients are prescribed opioid medication for chronic pain
  1. Evidence
  2. Advantages/Limitations
- **Test features:**
  1. Time: Less than one minute to administer
  2. Length: 5 items
  3. Administered by: Patient self-administration
  4. Target Population: Adults
  5. Intended Settings: Primary care
  6. Developed by: Lynn Webster, MD
- **Scoring and interpretation:**



1. The ORT can be scored by hand, either by the patient or the health professional. Each item that the patient answers positively is awarded a value; values for the entire assessment are added to obtain a patient's opioid risk score, which is broken down into low (0-3), moderate (4-7), and high (>7) risk.
- **Available Formats:**
    1. [Printable ORT](#)
    2. [Printable ORT with Scoring Interpretation](#)

## SOAPP: SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN

- **Purpose:** Patients at high risk for opioid abuse
  - Evidence
  - Advantages/Limitations
- **Test features:**
  - Time: 5-10 minutes to administer and score
  - Length: Short and Long-item formats are available, including three formats of 5, 14 and 24 items. A revised version (SOAPP-R) includes a toxicology report.
  - Administered by: Patient self-administration
  - Target Population: Adults
  - Intended Settings: Primary care
  - Developed by: Stephen F. Butler, 2003 for Inflexxion, Inc.
- **Scoring and interpretation:**
  - The SOAPP can be scored by the health professional by adding the ratings for 14 of the 24 questions. A score of 7 or above indicates increased risk for abuse.
- **Available Formats:**
  - [View SOAPP on PainEDU.org \(requires registration\)](#)

## DIRE: DIAGNOSIS, INTRACTABILITY, RISK, EFFICACY

- **Purpose:** Assesses risk of opioid abuse and suitability of candidates for long-term opioid therapy
  - Evidence
  - Advantages/Limitations
- **Test features:**
  - Time: less than 2 minutes to administer and score
  - Length: 7 items
  - Administered by: Patient interview
  - Target Population: Adults
  - Intended Settings: Primary care
  - Developed by: Dr. Miles J. Belgrade in 2005
- **Scoring and interpretation:**
  - Patient's score on the DIRE (between 7 and 21) correlates with efficacy of opioid therapy and compliance<sup>70</sup>.
- **Available Formats:**

- [Printable DIRE](#)

## COMM: CURRENT OPIOID MISUSE MEASURE

- **Purpose:** Monitors chronic pain patients on opioid therapy by asking patients to describe how they are currently using their medication. Can also be used to develop treatment strategies for minimizing continued misuse.
  - Evidence
    - Validated by the International Association for the Study of Pain<sup>71</sup>
  - Advantages/Limitations
- **Test features:**
  - Length: 17 or 40 items
  - Administered by: Patient Self-Report
  - Target Population: Adults
  - Intended Settings: Specialty Pain Management and Primary care
  - Developed by: Endo Pharmaceuticals and the National Institute on Drug Abuse
- **Scoring and interpretation:**
  - Less than 10 minutes to administer and score.
- **Available Formats:**
  - [Online COMM](#)

## SAMPLE CASES AT EACH LEVEL OF RISK

### **Low Risk: Fibromyalgia - Ms. Janet Robinson, 32YOWF**



**Patient:** Ms. Janet Robinson

**Chief Complaint:** Increasingly severe pain from fibromyalgia

**Narrative:** Janet Robinson was recently diagnosed with fibromyalgia and it is not responding as well as she would like to try typical fibromyalgia treatment, despite following recommendations of a physical therapist and participating in cognitive behavioral therapy. Pain is not responding to combinations of

acetaminophen, NSAIDs, antidepressants, or anti-seizure drugs that are often effective in fibromyalgia so she feels she needs something to treat the chronic pain. She is also looking for a new physician because her long-time family doctor recently retired.

**Relevant Past Medical, Psychosocial, Family History:** Onset of fibromyalgia 2 years ago following divorce; remains single, but has a good support system.

#### **Opioid Risk Factors:**

- Personal or family history of substance use problems: None
- Mental health conditions: None
- History of adult or childhood sexual, physical or emotional trauma: None

**Medium Risk: Knee Pain - Mr. Jeff Reed, 20YOWM**

**Patient:** Mr. Jeff Reed

**Chief Complaint:** Needs additional medication to treat knee pain

**Narrative:** Jeff Reed has been active in various recreational sports for all his life and identified as an athlete until his knee injury 2 years ago. Since then, he has taken NSAIDs, and they were effective until he became depressed a half year ago. His depression lifted with treatment with counseling and a SSRI antidepressant, but he still has constant moderate pain. He requests something stronger for the pain.

**Relevant Past Medical, Psychosocial, Family History:** Knee surgery (torn meniscus) 2 years ago; brother with history of substance abuse. He has a history of successfully treated depression. He recently stopped his antidepressant because he was feeling better and he did not like the side effects.

**Opioid Risk Factors:** Recent depression; family member with substance abuse history.

**High Risk: Headache - Mrs. Hanna Collins, 28YOBF**

**Patient:** Mrs. Hanna Collins

**Chief Complaint:** Daily headache that she says only responds to a combination of acetaminophen and oxycodone but she has run out.

**Narrative:** Hanna Collins has daily chronic headaches and found that they did not respond to NSAIDs but did respond to acetaminophen/oxycodone taken after a C-section. She was on antidepressants for post-partum depression but stopped them due to the expense; she reports still feeling depressed. She reports drinking two to three alcoholic drinks per day.

**Relevant Past Medical, Psychosocial, Family History:** C-section delivery 1 year ago. Her obstetrician prescribed a combination of acetaminophen/oxycodone after the initial C-section and then again after repair surgery; 4 children; chronic daily headaches for several years, postpartum depression. She has seen several other primary care providers for the headache.

**Opioid Risk Factors:** Previously undiagnosed alcohol abuse, comorbid depression, multiple opioid prescribers.

## CASE: MS. COBB PART 3



**Patient:** Ms. Paula Cobb, 29 years old

**Chief Complaint:** Needs additional medication to treat hip bursitis

**History of Present Illness:** Ms. Cobb is a long-distance runner who developed bursitis in her right hip and buttock last year. In the past 6 months her condition has been treated with various NSAIDs, and yet she still had moderate pain and limited range of motion in her leg and hip. Earlier in her treatment, she had several cortisone injections, which helped "about 50%", but she does not want to continue them long term because of side effects. She requests help for her undertreated pain.

PROVIDER-PATIENT DIALOGUE FOR STRATIFICATION OF RISK:

Dialogue about co-occurring psychiatric conditions

**Provider:** *Have you found yourself anxious or depressed recently?*

**Ms. Cobb:** *No, not depressed, but sometimes I'm anxious about the pain.*

**Provider:** *I see. And how would you describe your social support, including family and friends?*

**Ms. Cobb:** *It's good. I'm close to my family and my husband, and I have several close friends and a group I have fun with.*

Dialogue about personal or family history of aberrant alcohol and drug-related behaviors

**Provider:** *Is there anyone in your family with substance abuse problems, such as alcoholism or drug dependencies, or a history of such problems?*

**Ms. Cobb:** *No, just my father; he's a recovered alcoholic.*

**Provider:** *Have you had any substance abuse problems, such as alcoholism or drug dependencies, or a history of such problems?*

**Ms. Cobb:** *No, not at all.*

Dialogue about history of physical or sexual abuse

**Provider:** *Did you experience any abuse as a child - physical, emotional, or otherwise?*

**Ms. Cobb:** *No.*

**Question:** Based on the information in this patient interview, what level of risk does Ms. Cobb have?

1. No risk
  - Feedback: Incorrect. Ms. Cobb has at least low risk because of past depression, current mild anxiety, and a father who is a recovered alcoholic.
2. Low to Medium Risk
  - Feedback: Correct. Ms. Cobb has low risk to moderate risk because of past depression, current mild anxiety and a father who is a recovered alcoholic.
3. High Risk
  - Feedback: Incorrect. Ms. Cobb has low risk to moderate risk because of past depression, current mild anxiety and a father who is a recovered alcoholic.
4. High
  - Feedback: Incorrect. Ms. Cobb has low risk to moderate risk because of past depression, current mild anxiety and a father who is a recovered alcoholic.

**Question:** What level of care is appropriate for Ms. Cobb? [Check all that apply]

1. Primary Care
  - Feedback: Potentially Correct. Patients with low risk of substance abuse can be managed in primary care. However, specialty consultation may be required, depending upon the provider's training and experience.
2. Primary care in consultation with specialists

- Feedback: Potentially correct. Patients with low risk of substance abuse can be managed in primary care. Specialty consultation may be required, depending upon the provider's training and experience.
3. Referral to specialist(s)
    - Feedback: Incorrect. Patients with low risk of substance abuse can be managed in primary care.

**Question:** Which of the methods below should you employ as part of taking universal precautions?  
(Check all that apply)

1. Having clear treatment goals
  - Feedback: Although Ms. Cobb has low risk and her pain can be managed in primary care, "universal precautions in pain management" are advised to prevent and detect abuse, particularly in light of her mild anxiety. The three precautions listed are among the 8-10 precautions that are recommended for all patients on chronic opioid therapy.
2. Paying attention to psychological and substance use issues
  - Feedback: Correct. Although Ms. Cobb has low risk and her pain can be managed in primary care, it is still advised to take "universal precautions in pain management" to prevent and detect abuse, particularly in light of her mild anxiety. The three precautions listed are among the 8-10 precautions that are recommended for all patients on chronic opioid therapy.
3. Regular assessments of pain and function as long as the treatment continues
  - Feedback: Correct. Although Ms. Cobb has low risk and her pain can be managed in primary care, it is still advised to take "universal precautions in pain management" to prevent and detect abuse, particularly in light of her mild anxiety. The three precautions listed are among the 8-10 precautions that are recommended for all patients on chronic opioid therapy.

## GOVERNMENT REGULATIONS

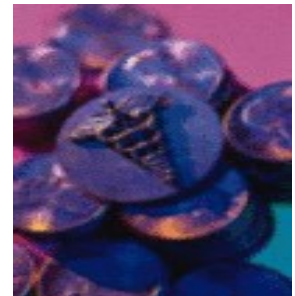
### Regulations on Controlled Substances

Prescribers must comply with applicable state and federal law<sup>72</sup>. Federal regulations regarding the prescription of controlled substances are strictly enforced and awareness of these regulations is essential to good practice. State regulations and state regulatory agencies also oversee prescription of controlled substances. Substantial changes in policy have occurred in over the years<sup>9</sup>. It is important to stay up to date on changes as they occur.

### Requirements of a Legal Prescription

The federal Comprehensive Drug Abuse Prevention and Control Act of 1970, or the Controlled Substances Act, describes the legalities of prescription drugs. The controlled substance regulations state that:

1. All prescriptions for controlled substances must:
  - Be dated and signed on date issued.
  - Display full name and address of patient.



- Include drug name, strength, dosage form, quantity prescribed, and directions for use.
  - Be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.
2. Medical records should accurately reveal the conditions which resulted in the prescription.
  3. Prescriptions for controlled substances may not be phoned in unless it is a true emergency, in which case the written prescription must be issued to the pharmacist within seven days and must clearly state its purpose for authorization for emergency dispensing.
  4. Practitioners may write prescriptions for controlled substances electronically (due to DEA revised regulations in 2010), but it is only slowly becoming reality due to the stringent rules and certification requirements.
    - This use of modern technology will allow pharmacies, hospitals, and practitioners to maintain control of dispensing substances, reducing prescription errors caused by illegible handwriting and misunderstood oral instructions, as well as integrate prescription records directly into medical records.

### Regulations on Use of Opioids to Treat Addiction

Only opioid treatment programs (OTPs) may dispense methadone for the treatment of opioid addiction. Buprenorphine sublingual tablets may be prescribed in an office-based setting to treat opioid addiction, only by a properly waived and certified provider<sup>73</sup>. Otherwise, opioids may not be prescribed to treat opioid addiction, either for detoxification or maintenance.

### Federal and State Law Overlap

**Follow the most restrictive regulation.** State law regulations may be more restrictive than federal regulations, but can not be less restrictive. State laws may have certain limits and stipulations that federal laws do not. When there is a difference, the most restrictive regulation applies.

## STATE SPECIFIC OPIOID REGULATIONS

### Overview

Many states have their own controlled substance regulations and even specific opioid prescribing policies. The details for each state can be found in the state by state Related Resource on this page. Unique details from states that have been particularly active are provided on this page as examples.



### State: Washington

The State of Washington has a number of specific requirements and recommendations for pain management and prescribing opioids for chronic non-cancer pain that go beyond what has been described in this module. The rules are summarized here and can be viewed on their department of health website (See Related Resource link on this page). Note: Palliative, hospice/other end-of-life care, and management of acute pain are exempted.

#### Washington's Additional Recommendations ("should")

1. Each patient should receive narcotics from only one prescriber and one pharmacy

2. Long acting opioids and methadone should be prescribed only by those who fully understand them and are prepared to do careful monitoring. Four hours (lifetime) of continuing education program on this topic is recommended for anyone prescribing them.
3. Episodic care (e.g., emergency departments, urgent care) should consult prescription drug monitoring programs or other tracking system before prescribing narcotics, avoid prescribing opioids for chronic pain management or at the most, only prescribe enough until the patient can return to regular care, write prescriptions to require photo identification, include indication for the prescription in the form of an ICD code, and report violations of known treatment agreements back to the regular provider
4. Consider referring patients under 18 years old or with risk factors for opioid misuse

#### Washington's Additional Requirements ("shall")

1. Written treatment agreements are required for high-risk patients and should include written authorization for releasing the information to/receiving information from: emergency/urgent care departments, pharmacies, proper authorities in the event of apparent illegal activity
2. Periodic reviews of patients with chronic noncancer pain are required at least every 6 months; patients whose pain is relatively well-managed on a stable, relatively low dose (40 or less mg morphine equivalent), may be seen annually.
3. Consultation with a pain management specialist is mandatory for adults with a dose over 120 mg morphine equivalent (oral) per day. Consultations may be by office visit, phone, electronic, audiovisual. Exemptions include patients with pain managed on a stable, non-escalating dose; acute pain; a tapering dose and providers who have completed 12 hours of CE on pain management in the past 2 years or who are themselves pain specialists.

(Washington State)

#### **State: Florida**

The state of Florida has a similar statute for prescribing controlled substances, most of which falls within what has been covered in this module. The details can be found via the link in the Related Resources section on this page.

#### Florida's Additional Requirement ("shall")

The time for follow-up for a patient who is prescribed a controlled substance:

"The patient shall be seen by the physician at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain."

(Florida Legislature)

## MRS. THOMAS - CASE SUMMARY

### Case Summary



**Patient:** Mrs. Louis Thomas, 58 y/o

**Scenario:** Mrs. Thomas seeks pain medication for chronic neck pain that bothers her constantly every day. She says that a combination of over-the-counter medications and immediate release opioids do not provide her with enough pain relief. She has experienced the neck pain for the past 3 years.

In the first year, first line therapies, including NSAIDs and physical therapy, were tried, but the pain responded only slightly and progressed instead of improving.

Two years ago, she had a cervical discectomy for a herniated disc, followed by physical therapy, and continued an opioid pain medication plus acetaminophen. Neurological symptoms resolved but evidence-based treatments other than opioids only yielded some pain relief. Despite extensive diagnostic testing, including a negative electromyogram, a specific cause for Mrs. Thomas's pain was not identified. The provider who prescribed immediate release hydrocodone, refused to continue prescribing it. Mrs. Thomas says this was the only time she had significant pain relief. Subsequently, she says she had to quit doing prescribed exercises due to the pain.

The pain is now constant and severe around half the time and occurs every day. The pain is worse at night and after work, and is described as a burning ache that bothers her every day, sometimes causing her to miss work or skip social activities.

### MRS. THOMAS - WEIGH RISKS AND BENEFITS

**Patient:** Mrs. Louise Thomas, 58 y/o

**Scenario:** The provider, who is REMS trained in prescribing ER/LA opioids, considers first prescribing an immediate release opioid for Mrs. Thomas's severe, non-specific cervical myofascial chronic pain that bothers her daily. The plan is to titrate the dose carefully to an effective stable dose and then switch to an extended-release or long-acting opioid.

**Question:** Which of the following are risks of chronic opioid therapy that may affect Mrs. Thomas?

1. Constipation
  - Feedback: Correct. Constipation is a very common side effect. Nausea, sedation, and itching are also common.
2. Sedation
  - Feedback: Correct. Sedation is a common effect, especially in early treatment. Nausea, constipation, and itching are also common.
3. Addiction
  - Feedback: Correct. Even with relatively low risk, addiction is a possibility.
4. Overdose



- Feedback: Correct. Overdose is a possible risk, although she does not have a lot of risk factors for it. Risk of overdose is even greater when dose is being changed or if she takes any sedating medications.

## SUMMARY AND KEY POINTS

- Collaborate with the patient in joint decision-making to enhance patient self-efficacy and improve outcomes
- Opioids may be beneficial for severe acute pain with some special precautions and limitations
- Incorporate pain management and functional goals into the treatment plan
- Before initiating, weigh the risks and benefits of ER/LA opioid therapy
- Consider prescribing naloxone along with the initial opioid prescription, for patients requiring long term opioid therapy.
- Determine whether or not the patient is opioid tolerant when prescribing opioids and consult product information to learn whether it is safe with the patient's level of tolerance
- Select initial dose, individually, and titrate to the minimal effective dose slowly
- Prescribe adjunctive medications and non-pharmacological treatments to spare the opioid dose
- Practice "transparent documentation," when documenting treatment in the patient's record
- Understand and comply with state and federal regulations, follow the most restrictive regulation
- Create an "exit plan" or plan for stopping treating before starting opioid therapy with a patient
- Understand that patients with higher risk will require a higher level of treatment structure

## RESOURCES AVAILABLE THROUGH THIS MODULE:

- [CDC Guideline for Prescribing Opioids for Chronic Pain](#)  
Clinical guidelines, literature review, and analysis of the evidence on the use of opioids for chronic pain. Recommendations are also made for prescribing opioids for acute pain.
- [Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders](#)  
Comprehensive review article that explores the relationship between pain and substance abuse and offers suggestions for evaluation and treatment. Authors: Savage SR, Kirsh KL, Passik SD
- [DSM 5 Substance-Related and Addictive Disorders](#)  
The APA's breakdown on changes to substance-related addictive disorder diagnoses introduced by DSM-5. The document goes over substance use disorder, addictive disorders and briefly states the APA's position on caffeine use disorder.
- [Electronic Prescriptions for Controlled Substances; Final Rule](#)  
The DEA revised regulations to allow electronic prescriptions for controlled substances.
- [ER LA Opioid Analgesics REMS Safety Information](#)  
Selected Important Safety Information. Abuse Potential and Risk of Life-Threatening Respiratory Depression for ER/LA Opioid Analgesics
- [FDA announces safety labeling changes and postmarket study requirements for opioids](#)

FDA News Release 8/18/2016: FDA announces safety labeling changes and postmarket study requirements for extended-release and long-acting opioid analgesics. New boxed warning to include neonatal opioid withdrawal syndrome.

- [Florida Statute on Controlled Substance Prescribing 456.44](#)  
Scroll down to 456.44 to see the Florida Standards of Practice for controlled substance prescribing.
- [Infographic: State-by-state breakdown of opioid regulations](#)  
State by State Opioid Prescribing Policies
- [Official Federal Regulations for Prescribing Opioids](#)  
Official federal regulations concerning the use of controlled substances. The regulations address registration, prescription, and schedules of controlled substances, among other topics pertaining to controlled substances.
- [Opioid Use Disorder Diagnostic Criteria](#)  
The Diagnostic criteria for opioid use disorder,
- [SAMHSA Opioid Overdose Prevention Toolkit](#)  
This resource on SAMHSA's website includes several resources: Facts for Community Members; Essentials for First Responders; Safety Advice for Patients; Information for Prescribers; and Resources for Overdose Survivors and Family Members
- [State of Washington Pain Management Rules](#)  
State of Washington Department of Health website describes the law passed by this state that took effect in 2011 and 2012 to require commissions of several prescribing health professions to make rules on pain management and especially reducing the risk in use of narcotics in pain management. Links to the adopted rules for each health profession are found on this page.
- [The Clinical Opiate Withdrawal Scale \(COWS\)](#)  
An abstract that helps to define the Clinical Opiate Withdrawal Scale (COWS) and also briefly discusses opioid withdrawal. Authors: Wesson DR, Ling W
- [WHO Pain Relief Ladder](#)  
Developed by the World Health Organization in 1986, the Pain Relief Ladder recommends progressively increasing levels of pain treatment for cancer pain until there is pain relief. The ladder is sometimes used for treatment of non-cancer pain.

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