PHARMACIST'S LETTER

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PRESCRIBER'S LETTER

Appropriate Opioid Use

Chronic pain is often undertreated and can lead to disability, depression, and other problems.[2,19,22] In recent years, there has been increasing focus on ensuring that patients get their pain addressed. The U.S. Joint Commission considers pain assessment to be a patient right, and in 1996 the American Pain Society pioneered the concept of pain as the 5th vital sign.[21,22] Treating chronic pain may require the use of opioids. In Canada and the U.S., opioid prescribing doubled from the late 1990s to 2012.[23,24] With increased opioid usage has come increased misuse and diversion.[4,25] In fact, most prescription opioids used nonmedically are obtained from family and friends, who usually obtain them from a single prescriber.[26] Despite these concerning statistics, opioid prescribing seems to be plateauing or even decreasing based on data from 2011 to 2013.[20] This may be due to prescribing restrictions, education, prescription monitoring programs, and prescribing of abuse-deterrent formulations.[20,30] However, heroin use is up; this may be an unintended consequence of one or more of these changes.[20] With careful patient selection, education, and monitoring, opioids can be safe and effective tools for management of chronic noncancer pain.[2] This table provides resources to help clinicians managing chronic pain with opioids, one of the most challenging areas of clinical practice. Also check with your licensing body for information on state or provincial regulations pertaining to dosing limits, screening, monitoring, etc. For information specific to community pharmacy practice, get our *PL CE, Ensuring Appropriate Opioid Management in a Community Pharmacy Setting* (Pharmacists) (Pharmacy Technicians).

Abbreviations: ORT = Opioid Risk Tool; PTSD = post-traumatic stress disorder

Goal	Suggested Strategies or Resources
Limit opioid use for back pain.	• Do not use opioids first-line for back pain. • See our *PL Charts, Treatment of Acute Low Back Pain* and *Treatment of Chronic Low Back Pain*, for preferred treatments.
Limit opioid use for acute pain.	• Do not use opioids first-line for most kinds of acute pain. • Prescribe only enough for the anticipated duration of severe pain (usually three to seven days), then re-evaluate.[27,31] • Advise patients to wean off the opioid to over-the-counter (OTC) analgesics as their pain resolves.[1] • Do not prescribe extended-release opioids for acute pain.[1] • See our *PL Chart, Analgesics for Acute Pain*, for preferred treatments.
Identify appropriate/ inappropriate uses for chronic opioids.	• Chronic opioids are most appropriate for patients with moderate to severe pain unresponsive to nonopioids (e.g., acetaminophen or NSAIDs for osteoarthritis, tricyclics or anticonvulsants for neuropathic pain).[2,3] • Generally avoid opioids in pelvic pain, fibromyalgia, headaches, migraine, low back pain, temporomandibular disease, irritable bowel syndrome, ill-defined pain syndromes, and situations where secondary gain (e.g., money) or psychosocial factors are in play.[2,4,18]

More. . .

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Goal	Suggested Strategies or Resources

Identify patients at risk for opioid misuse.	• Screen for opioid abuse risk factors: younger age, history of psychiatric illness, personal or family history of substance abuse.[2,4]
	  • The Patient Health Questionnaire, a screening tool for depression, is available at http://www.cqaimh.org/pdf/tool_phq2.pdf.
	  • The Primary Care PTSD Screen is available at http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp.
	• Be wary of patients insisting on specific products or claiming allergies to specific analgesics; this is a red flag for drug-seeking behavior.[15] Use our *PL Algorithm, Opioid Intolerance Decision Algorithm*, to help find the best options for potentially allergic patients.
	• Risk assessment tools such as ORT (Opioid Risk Tool), SOAPP-R (Screener and Opioid Assessment for Patients with Pain, revised), and DIRE (Diagnosis, Intractability, Risk, Efficacy) are available at http://www.opioidrisk.com/node/3310. However, available evidence suggests these tools are not very accurate in distinguishing low-risk from high-risk patients.[31]
	• In the U.S., check your state's prescription drug monitoring program to identify patients who may be improperly using or diverting opioids and other controlled substances, or getting a benzo prescription from another prescriber. In Canada, use your provincial prescription or narcotic monitoring system, if available.
	• To prevent misuse and diversion of controlled substance prescriptions, it's important to watch for "red flags." For examples, see our *PL Detail-Document, "Red Flags": Tips for Appropriate Dispensing of Controlled Substances* (U.S.).

Reduce risk of overdose.
 	
Continued…
	• Screen for depression, suicidal ideation, and other mental health problems.[4,5]
	• Prescribe/dispense opioids in small quantities to at-risk patients.[4]
	• Keep in mind that women are at higher risk of overdose than men.[5]
	• If possible, avoid other respiratory/central nervous system depressants (e.g., benzodiazepines, barbiturates, diphenhydramine, muscle relaxants, promethazine).[5,6,12,13]
	• Start with a low dose of a short-acting opioid (e.g., oxycodone 5 mg every 4 to 6 hours as needed).[4,13] Reserve long-acting opioids for select patients.
	  • There's no proof long-acting opioids are safer or more effective.[16] In fact, the risk of unintentional overdose is over two-fold higher than with short-acting opioids, even after adjusting for dose and other factors, especially during the first two weeks.[13] Long-acting opioids are also associated with higher all-cause mortality compared to anticonvulsants or tricyclic antidepressants in chronic noncancer pain.[40]
	  • Save long-acting opioids for continuous, severe pain in patients who have achieved efficacy with short-acting agents.[31]
	• Try to avoid combining short- and long-acting opioids.[31] Some long-acting formulations can be given more frequently if breakthrough pain consistently occurs toward the end of the dosing interval. For example, *MS Contin* or *OxyContin* may be dosed every eight hours, or *Duragesic* every 48 hours.[41-45]

Goal	Suggested Strategies or Resources

Reduce overdose, continued	• Consider the partial opioid agonist buprenorphine for patients who need an opioid for chronic pain, but for whom an opioid with a wider margin of safety than full agonists is desirable. Our *PL Chart*, *FAQs About Buprenorphine for Chronic Pain*, provides an overview of this opioid that is unfamiliar to many clinicians.
	• Be aware that overdose risk increases significantly at doses of oral morphine >100 mg daily, or its equivalent.[11,a] The CDC recommends careful reassessment of benefits and risks before increasing the daily dose to ≥50 mg morphine or its equivalent (e.g., hydrocodone 50 to 75 mg or oxycodone 30 to 50 mg). They also recommend that clinicians should avoid increasing the dose daily to ≥90 mg morphine or its equivalent without careful justification.[31]
	• Dose methadone safely. Methadone safety guidelines can be found at http://www.jpain.org/article/S1526-5900(14)00522-7/pdf. These guideline and more are reviewed in our *PL Chart*, *Methadone for Pain: Focus on Safety*.
	  • Assess risks of arrhythmias. Baseline and periodic EKG is recommended for certain patients.
	  • Screen for drug interactions.
	  • Start with a low dose (e.g., 2.5 mg three times daily for patients switched from <40 to 60 mg/day of oral morphine or its equivalent,[a] increasing by no more than 5 mg/day every 5 to 7 days. This is **not** an equianalgesic dose conversion).
	  • Advise patients/caregivers to hold the dose and contact the prescriber in the event of respiratory depression or somnolence.
	• Use caution when switching between opioids. See our *PL Chart*, *Equianalgesic Dosing of Opioids for Pain Management*, for help.
	• Ensure that patients and caregivers understand not to break, split, or crush sustained-release formulations. Specific cautions and patient counseling points are available in our *PL Chart*, *Abuse-Deterrent Opioids.*
	• See "Naloxone" section, below.

Provide naloxone.	• Consider naloxone for patients with risk factors for overdose (e.g., high dose, switching from one opioid to another, history of overdose or substance abuse, etc).[14] • There is no "safe" opioid dose, but daily dosages of 50 to <100 mg oral morphine or its equivalent increase the risk of opioid overdose by about two- to five-fold compared to daily dosages of <20 mg morphine or its equivalent.[a] Daily dosages of ≥100 mg morphine or its equivalent are associated with a two- to almost nine-fold higher risk compared to daily dosages of <20 mg of morphine or its equivalent.[31] • Learn more about naloxone in our *PL Chart*, *Naloxone for Opioid Overdose: FAQs*, and in our *PL CE LIVE: Special Edition: Overdose Prevention with Naloxone*, archived webinar. • Information about naloxone of specific interest to pharmacists is available in or *PL CE*, *Naloxone Rescue Therapy for Opioid Overdose*. • Information on preparing and prescribing naloxone rescue kits is available at www.prescribetoprevent.org. • With permission from the Prescribe To Prevent group, prescription forms with tear-off patient instructions are being made available to subscribers of *Pharmacist's Letter/Prescriber's Letter*: *Naloxone for Overdose Prevention (intramuscular)*

Continued…

Goal	Suggested Strategies or Resources
Provide naloxone, continued	and *Naloxone for Overdose Prevention (intranasal)*. • The College of Pharmacists of British Columbia has additional resources, including patient handouts, at http://www.bcpharmacists.org/naloxone.
Manage patient expectations.	• Set goals with the patient for functional improvement, and document them for future monitoring purposes; this is how efficacy will be determined.[4] • Explain that improving pain and function by about 30% is a success.[4,31] • Explain that evidence of long-term benefit is lacking.[16] • Think SMART: the goals should be Specific, Measurable, Action-oriented, Realistic, and Time-dependent.[32] • View the opioid prescription as a time-limited trial; you are testing benefit to the patient, not committing to long-term opioid use.[32]
Educate patients about opioid safety.	• An educational poster from the CDC promoting non-opioid alternatives is available at http://www.cdc.gov/drugoverdose/pdf/guidelines_patients_poster-a.pdf. • A patient fact sheet from the CDC discussing opioid risks, opioid alternatives, and measures to improve opioid safety is available at http://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-patients-a.pdf. • Patient counseling should include advice to avoid driving during dose increases or if they are sedated. Patients should be told to avoid using alcohol or sedating drugs. If they do, they should not drive.[4] • Patients should be counseled on how to safely store and dispose of opioids.[5] Treatment agreements often include an expectation of secure storage. • Apprise patients of the risks of chronic opioid use, including hypogonadism, sleep apnea, tolerance, hyperalgesia (i.e., pain sensitization caused by chronic opioid use), withdrawal, and addiction, at baseline and periodically.[2,4,13,28]

Prevent and identify misuse.
 	
Continued…
	• Consider a treatment agreement, at minimum, for patients at high risk of misuse, or patients not well known to the prescriber. Some experts feel that a treatment agreement is needed for all patients receiving opioids for chronic noncancer pain.[5] See our *PL Detail-Document*, *Opioid Treatment Agreements*, for more information, including links to sample agreements.
	• Require in-person follow-up in order for patients to obtain a refill or new prescription.
	• Consider pill counts.[32]
	• Consider urine drug testing.
	  • The U.S. Centers for Disease Control and Prevention (CDC) recommends baseline urine drug testing before prescribing chronic opioids, and that consideration be given to testing at least annually.[31]
	  • Some experts recommend urine drug testing at baseline (to identify risk), one to three months after therapy initiation, then random testing every six to 12 months.[3]

Goal	Suggested Strategies or Resources
Prevent/identify misuse, continued	• Consider testing three or four times per year in patients at high risk per ORT, or taking >120 mg of morphine daily.[13] • If urine testing is planned, either at baseline or follow-up, know how to interpret the results and plan how you will apply them.[4] For help, see our *PL Chart*, *Urine Drug Testing*. • Consider abuse-deterrent formulations. Our *PL Chart*, *Abuse-Deterrent Opioids*, describes the deterrent mechanism and precautions/counseling points for each formulation. Keep in mind these products have not been proven to prevent opioid misuse. • Pharmacists can get our *PL CE*, *The Balancing Act with Controlled Substances: Ensuring Access for Patients with Valid Prescriptions*, to learn what they can do to help keep controlled substances out of the wrong hands, while ensuring safe access for patients with legitimate need.

Ensure appropriate follow-up and evaluation of opioid therapy.	• Schedule follow-up every one to four weeks while determining the optimal dose.[4,17] Treatment agreements generally require in-person follow-up in order for patients to obtain a refill or new prescription.
	• Chronic pain is often accompanied by impaired function, multiple medical conditions, and psychological disorders.[2] Address these areas in addition to evaluation of efficacy (i.e., improved function and pain control), adverse effects, and evidence of misuse.[4]
	  • An assessment tool for function, the SF36 Health Survey, is available at http://www.rand.org/health/surveys_tools/mos.html.
	  • A checklist for adverse effects, function, and opioid dependence is available from the Utah Department of Health at http://health.utah.gov/prescription/pdf/guidelines/checklist%20for%20adverse%20effects.pdf.
	  • An assessment tool for pain, the Brief Pain Inventory, is available at http://www.painedu.org/Downloads/tools/bpilong.pdf.
	• The two-item version of the Graded Chronic Pain Scale is available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf (See Figure B). It measures pain intensity and related disability.
	• Consider re-evaluation of therapy before increasing the daily dose to 50 mg of oral morphine or its equivalent, and again before increasing the dose to 90 mg of morphine or its equivalent.[31,a]
	  • Consider pain management consult, particularly if pain and function have not significantly improved.[12]
	  • Assess diagnosis, pain control, function, and adverse effects.[4]
	  • Use a checklist to help ensure all areas are covered.
	  • Consider the possibility of misuse or hyperalgesia.[4]
	  • Consider more frequent monitoring.[4]

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Goal	Suggested Strategies or Resources

Use appropriate adjunctive therapy.	• Maximize dosing of nonopioid pain medications before opioids are used.[2,3]
	• Integrate interdisciplinary therapy. This usually involves exercise and psychological therapy.[2]
	  • Cognitive-behavioral therapy is the best-studied psychological intervention and has been shown to help patients cope with chronic pain.[2]
	  • Supervised therapy for stretching, strengthening, and aerobic exercise may be appropiate.[13]
	• In addition, proper sleep hygiene is recommended.[13]
	• To prevent constipation, prescribe an osmotic laxative (PEG 3350, etc) or a stimulant laxative with opioids.[29] Fluids, fiber, and exercise can also be recommended.[8,29]
	• Ensure associated comorbidities are treated (e.g., depression, obesity).

Discontinue opioids when appropriate.	• If misuse occurs, evaluate whether continuation of chronic opioid therapy is appropriate. Restructuring of therapy (e.g., more intensive monitoring, opioid tapering, addition of nonopioid or psychiatric treatment) or referral may be indicated.[2]
	• Consider dose reduction or tapering and discontinuation in the event of inefficacy, intolerable side effects, signs of intoxication, overdose, evidence of diversion, or suspected hyperalgesia.[2,9,10]
	  • High-quality evidence to guide tapering is lacking; individualize.
	  • The reason for discontinuation and amount of opioid being used will influence the rate of taper.
	  • High doses may be able to be tapered rapidly (e.g., 25% to 50% every few days) until reaching 60 mg to 80 mg of oral morphine or its equivalent.[a] Then the rate can be slowed (e.g., 10% of the original dose per week) to prevent withdrawal.[2,13]
	  • If the opioid is being tapered due to misuse, offer addiction treatment and nonopioid pain management.[2] (See next section.)
	  • Keep in mind that for some patients, the goal will be a lower but still effective dose, not complete discontinuation.[13,33]
	• When talking to patients about opioid discontinuation, explain that:
	  • most patients feel better without opioids if they are not getting good pain relief.[7]
	  • you are not abandoning them. Their pain will be addressed with nonopioid alternatives.[13,33,34]
	  • most patients do not experience increased pain.[2,35]
	  • withdrawal symptoms are uncommon if the dose is tapered slowly.[34]
	• For more practical information on this topic, and additional tapering protocols, see our *PL Chart, Opioid Discontinuation: FAQs*.

Goal	Suggested Strategies or Resources
Offer treatment for opioid use disorder.	• Medication-assisted treatment of opioid use disorder has the most evidence and helps prevent withdrawal symptoms, decreases rates of illicit opioid use, reduces criminal activity, and improves social function.[36,37] • Our *PL Chart, Management of Opioid Dependence*, covers common clinical questions about approved medication-assisted treatments for opioid use disorder, with a focus on buprenorphine/naloxone. • Find a physician in your area authorized to prescribe buprenorphine for opioid dependence at http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator.

Manage opioids appropriately in the inpatient setting.	• In the emergency department or urgent care:
	  • prescribe only enough opioid doses to get the patient through to their follow-up appointment[1]
	  • do not prescribe long-acting opioids (except in hospice patients, with hospice consultation)[27,39]
	  • check your state/provincial prescription drug monitoring program before writing an opioid[27,39]
	  • communicate with the patient's outpatient prescriber.[27]
	• Continue any long-term, pre-op opioids in most surgical patients to avoid opioid withdrawal during hospitalization.[38]
	• Our *PL Chart, Management of Opioid Dependence*, includes tips on managing acute pain in hospitalized patients taking methadone or buprenorphine for opioid use disorder.
	• Don't assume all post-op patients require opioids.[38]
	• Use multimodal analgesia (e.g., scheduled acetaminophen or an NSAID; gabapentin or pregabalin [e.g., gabapentin 600 to 1200 mg or pregabalin 150 to 300 mg one to two hrs pre-op]; local or regional anesthesia; TENS) for its opioid-sparing effects; perioperative opioid use is associated with subsequent long-term opioid use.[38]
	• Use oral opioids as opposed to intravenous opioids when possible.[38] If this is not possible, use patient-controlled analgesia (PCA)(without a basal setting in opioid-naïve patients).[38]
	• Patients who are not on opioids chronically, but who are prescribed them post-op, can be told to taper their dose by 20% to 25% each day or every other day once pain is improving.[38]
	• Also instruct patients on disposing any leftover doses.[27,38] Share our *PL Patient Education Handout, Medication Disposal Guide*, to help explain the disposal options in the U.S.

Where permitted by law, ensure appropriate use of medical marijuana for pain.	• See the College of Family Physicians of Canada's preliminary guidance on cannabis use for chronic pain at http://www.cfpc.ca/uploadedFiles/Resources/_PDFs/Authorizing%20Dried%20Cannabis%20for%20Chronic%20Pain%20or%20Anxiety.pdf.

a. See our *PL Chart, Equianalgesic Dosing of Opioids for Pain Management*.

Users of this PL Detail-Document are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.

Project Leader in preparation of this PL Detail-Document: *Melanie Cupp, Pharm.D., BCPS*

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