Key Patient Management Considerations When Prescribing Opioids for Pain

1. Assess appropriate candidates for prescription opioid treatment

History

- Current specific pain symptoms[1-3]
- Past pain, imaging, treatment, consultations, procedures, etc. (get old records)[2-4]
- Chronic medical problems[1-3]
  - Medications: All, including OTC; verify via a Prescription Drug Monitoring Program (PDMP)—eg, the California Controlled Substance Utilization Review and Evaluation System (CURES)—or via urine drug screening[2]
- Alcohol and drug use: Current and past[1,2]
- Mental health[1,2]
- Opioid Risk Tool, Screener and Opioid Assessment for Patients with Pain, or similar*[2,3]

Additional diagnostic evaluation as indicated

- Imaging: Consider on the basis of pain level, injury, chronicity[2,3]
- Laboratory tests (including urine drug testing, renal and liver function)[1-3]
- Additional testing as needed

Physical examination[2]

- Vital signs
- General examination
- Specific detailed examination: Area of symptoms

Assessment of physical cause of pain[1,2]

- As specific as possible (eg, lumbar radiculopathy rather than back pain)

2. Select appropriate opioid treatment for each patient

Treatment plan with goals (must be medically justified): Individualized[1-3]

- Informed Consent about risks and benefits (see Opioid Prescribing Guidelines on next page)

3. Establish opioid treatment goals and set patient expectations

Controlled substance agreement[2,3]

- Optional, but should be considered
- Web links for sample forms:
  - https://www.aafp.org/fpm/2010/1100/fpm20101100p22-rt1.pdf
  - https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf

Medical records documentation

- Thorough documentation is necessary for patient safety, billing purposes, and to meet legal requirements[2,3]

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*Find at https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf or at https://d1li5256ypm7oi.cloudfront.net/colospine/2016/08/SOAPP-R-Screener-and-Opioid-Assessment-for-Patients-with-Pain-Revised-160816-57b258fc9a277.pdf

4. Manage and monitor opioid treatment

Consultation[1,2,4]

- When there is failure to improve or deterioration

Monitoring

- CURES or other PDMP[1-3]
- Urine drug screening[1-3]
- Laboratory testing: As indicated; patient-specific[2]
- Updated brief history, examination, assessment[2]
- Morphine Equivalent Dosing (MED) calculation and monitoring[2]

Periodic review (follow-up visits)[2-4]

- Analgesia: Pain control
- Activities of daily living
- Adverse effects (including signs/symptoms of opioid withdrawal)
- Emotional demeanor/responses
- Aberrant behaviors

Note: Always think about tapering opioid dosages if possible

Excessive or high-dose opioids: 90 mg/d MED, also referred to as morphine milliequivalents[1,2]

Control and Prevention [CDC] 2016 Opioid Prescribing Guidelines Summary[1,2]

- Avoid benzodiazepines with opioids (increases risk of overdose and death vs opioid-only use)[1]
- Perform periodic risk-benefits evaluation, including PDMP database review and urine drug screen[1]
- Prescribe non-pharmacologic and non-opioid treatment as first line[1]
- Discuss risk-benefits with patients and document
  - Explain that opioid tolerance/dependence may develop and opioid withdrawal symptoms may occur when treatment is reduced/discontinued[5-7]
- For chronic pain, avoid opioids; risks outweigh benefits for most
- Establish realistic goals before opioid therapy starts[1]
- Start with immediate-release opioids; avoid methadone as first line because of higher risk[1]
- Use additional precautions if dose exceeds MED of 50 mg/d[1]
- Generally, avoid increasing the dosage to MED 90 mg/d[1]
- Prescribe a maximum of only 3 days of opioids for most acute nontraumatic, nonsurgical pain[1]

Potential Risks/Side Effects of Opioid Medications*[2]

- Misuse
- Development of physical opioid tolerance/dependence or Opioid Use Disorder (OUD)[5-7]
- Overdose death[8]
- Opioid withdrawal symptoms if abruptly stopped or dosage reduced[5-7]
- Serious, life-threatening, or fatal respiratory depression[8]
- Severe hypotension[8]
- Androgen deficiency[8]
- Depression and anxiety[8]
- Opioid-induced hyperalgesia[8]
- Liver toxicity[8]

*Before prescribing any opioid, it is important to consult the FDA-approved labeling for the specific opioid and have a full understanding of the potential risks associated with that opioid. Make sure to review and consider all warnings in the labeling for the specific opioid.

References: 1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. MMWR Recomm Rep 2016 Mar 1;65(1):1-49. DOI: https://doi.org/10.15585/mmwr.rr6501e1. Erratum in: MMWR Recomm Rep 2016 Mar 25;65(11):295. DOI: https://doi.org/10.15585/mmwr.mm6511a6. **2.** Munzing T. Physician guide to appropriate opioid prescribing for noncancer pain. *Perm J.* 2017;21:1-7. **3.** Medical Board of California. Guidelines for prescribing controlled substances for pain. Sacramento, CA: Medical Board of California; 2014 Nov. https://www.mbc.ca.gov/licensees/prescribing/pain_guidelines.pdf. Accessed March 12, 2018. **4.** American Academy of Pain Medicine. Use of opioids for the treatment of chronic pain. Chicago, IL: American Academy of Pain Medicine, 2013. https://www.painmed.org/files/use-of-opioids-for-the- treatment-of-chronic-pain.pdf. Accessed March 12, 2018. **5.** Kleber H. Opioids: detoxification. In: Galanter M, Kleber, HD, eds. *Textbook of Substance Abuse Treatment.* 2nd ed. Washington, DC: American Psychiatric Press;1999:251-269. **6.** Kosten TR, George TP. The neurobiology of opioid dependence: implications for treatment. *Sci Pract Perspect.* 2002;1(1):13-20. **7.** Shigakova F. Clinical manifestations of the opiate withdrawal syndrome. *Int J Biomed.* 2015;5(3):151-154. **8.** Benyamin R, Trescot AM, Datta S, et al. Opioid complications and side effects. *Pain Physician.* 2008;11(2 Suppl):S105-120.

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