

Key Patient Management Considerations When Prescribing Opioids for Pain

1. Assess appropriate candidates for prescription opioid treatment



History

- Current specific pain symptoms¹⁻³
- Past pain, imaging, treatment, consultations, procedures, etc. (get old records)²⁻⁴
- Chronic medical problems¹⁻³
 - 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 screening²
- 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 examination²

- 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): Individualized¹⁻³

- 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://d11i5256ygm7oi.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 PDMP¹⁻³
- Urine drug screening¹⁻³
- Laboratory testing: As indicated; patient-specific²
- Updated brief history, examination, assessment²
- Morphine Equivalent Dosing (MED) calculation and monitoring²

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 screen¹
- Prescribe non-pharmacologic and non-opioid treatment as first line¹
- Discuss risk-benefits with patients and document
 - Explain that opioid tolerance/dependence may develop and opioid withdrawal symptoms may occur when treatment is reduced/discontinued⁵⁻⁷
- For chronic pain, avoid opioids; risks outweigh benefits for most
- Establish realistic goals before opioid therapy starts¹
- Start with immediate-release opioids; avoid methadone as first line because of higher risk¹
- Use additional precautions if dose exceeds MED of 50 mg/d¹
- Generally, avoid increasing the dosage to MED 90 mg/d¹
- Prescribe a maximum of only 3 days of opioids for most acute nontraumatic, nonsurgical pain¹

Potential Risks/Side Effects of Opioid Medications^{*2}

- Misuse
- Development of physical opioid tolerance/dependence or Opioid Use Disorder (OUD)⁵⁻⁷
- Overdose death⁸
- Opioid withdrawal symptoms if abruptly stopped or dosage reduced⁵⁻⁷
- Serious, life-threatening, or fatal respiratory depression⁸
- Severe hypotension⁸
- Androgen deficiency⁸
- Depression and anxiety⁸
- Opioid-induced hyperalgesia⁸
- Liver toxicity⁸

*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 16;65(1):1–49. DOI: <https://doi.org/10.15585/mmwr.mm6501e1>. 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/licenses/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 E. 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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