

# Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain Safety Guideline

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Last guideline approval: September 2016

**Guidelines** are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.

## Major Changes as of September 2016

- A list of **Kaiser Foundation Health Plan of Washington provider expectations** has been added, with the aims of decreasing practice variation, improving patient safety, ensuring compliance with Washington State law, and ultimately increasing both patient and provider satisfaction.
- Continuation of chronic opioid therapy should be considered only when it is associated with **clinically meaningful improvement in function (CMIF)**, defined as an improvement in pain and function of at least 30% as compared to the start of treatment or in response to a dose change.
- The **PEG Tool** (Pain intensity, interference with Enjoyment of life, and interference with General activity) has replaced the Chronic Pain Scale as the **preferred tool for documenting pain and function**.
- The **definition of high-risk COT dosing** has changed from  $\geq 120$  mg MED to  **$\geq 90$  mg MED**, per the 2016 guideline of the Centers for Disease Control and Prevention (Dowell 2016).
- Every COT patient must have **at least one office visit per year dedicated to COT monitoring**. Other monitoring visits can be opportunistic and conducted in person, by phone, or by secure messaging.
- A COT monitoring visit is now required **every 3 months for patients in the high-risk monitoring group**, instead of every 6 months.
- Prescribing **naloxone** as a preventive rescue medication for all patients taking  $\geq 40$  mg MED and their families is now recommended.
- It is now recommended that COT patients **be screened for opioid use disorder** using the Substance Use Disorder Checklist.
- Principles to **prevent conversion from acute to chronic opioid therapy** have been added, with links to an external guideline.

This guideline is in compliance with the State of Washington regulations [WAC 296-919-850–863](#) on the use of opioids in the treatment of patients with chronic non-cancer pain.

## Guideline Scope

Kaiser Foundation Health Plan of Washington has adopted the recommendations of the [2015 Agency Medical Directors' Group \(AMDG\) Interagency Guideline on Prescribing Opioids for Pain](#).

**This is a safety guideline.** The recommendations in this guideline apply to adult patients who are **already on chronic opioid therapy (COT)** for the treatment of **chronic non-cancer pain**.

**Chronic opioid therapy (COT)** is daily or near-daily use of opioids for at least 90 days, often indefinitely (Chou 2009). Additionally, COT is defined as a minimum 70-day supply of opioids dispensed in the previous 3 calendar months.

**Chronic non-cancer pain** means a state in which non-cancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years (WAC 246-919-850).

Indications for and initiation of opioid prescribing are **outside the scope** of this guideline, as are general recommendations for the treatment of chronic non-cancer pain. For these areas, Kaiser Foundation Health Plan of Washington has adopted the recommendations of the [2015 AMDG Interagency Guideline on Prescribing Opioids for Pain](#).

The Centers for Disease Control and Prevention has found insufficient evidence to determine the long-term benefits of opioid therapy for chronic pain, and has found an increased risk for serious harms related to long-term opioid therapy that appears to be dose-dependent. (CDC 2016)

This guideline does **not** apply to patients receiving palliative, hospice, or other end-of-life care.

# Preventing Conversion from Acute to Chronic Opioid Therapy: General Principles

The best way to minimize chronic opioid use is to minimize acute opioid prescribing. Sixty percent of patients who take opioids for 3 months are still taking them 5 years later. (AMDG 2015)

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than that needed for the expected duration of pain severe enough to require opioids. (CDC 2016)

For acute, subacute, and perioperative prescribing, general principles from the AMDG guideline are listed here. Refer to the [full AMDG guideline](#) for more detailed recommendations.

## **Acute phase** (0–6 weeks post episode of pain or surgery)

- Check the state's [Prescription Monitoring Program \(PMP\)](#) before prescribing.
- Don't prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Three days or less will often be sufficient; more than seven days will rarely be needed. (CDC 2016)
- Opioid use beyond the acute phase is rarely indicated.

## **Subacute phase** (6–12 weeks post episode of pain or surgery)

- Don't continue opioids without clinically meaningful improvement in function and pain (CMIF).
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the [PMP](#) and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

## **Perioperative** (preoperative through time of hospital discharge)

- Evaluate thoroughly preoperatively: Check the [PMP](#) and assess for risk for over-sedation and difficult-to-control pain.
- Tapering opioids is not required before surgery, but avoid escalating the dose before surgery. Set appropriate expectations with patients that their pain management needs will be met following surgery, with the understanding that they will return to their preoperative dose (or less) following surgery.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

## **Special populations**

- Pregnant women: Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- Elderly patients: For older adults, initiate opioids at a 25–50% lower dose than for younger adults.
- Adolescents and children: Avoid prescribing opioids for most chronic pain problems.
- Cancer survivors: Rule out recurrence or secondary malignancy for any new or worsening pain.

## Washington State Law

This guideline is in compliance with the State of Washington regulations [WAC 296-919-850-863](#) on the use of opioids in the treatment of patients with chronic non-cancer pain. (See Appendix E, p. 28.)

## Expectations for Kaiser Foundation Health Plan of Washington Providers

Using protocols and standard documentation, Kaiser Foundation Health Plan of Washington aims to minimize practice variation in the management of patients on chronic opioid therapy for chronic non-cancer pain, which will improve patient safety, ensure compliance with Washington State law, and ultimately increase both patient and provider satisfaction.

- ✓ Patients on COT shall be **risk-stratified** to the highest appropriate category by the prescribing clinician. See “Risk stratification and intensity of monitoring,” p. 6.
- ✓ Patients on COT shall have **regular COT monitoring visits** that:
  - Occur at a **frequency** based on the patient’s risk stratification (see “Frequency of COT monitoring visits,” p. 6), and
  - Include **standard components** (see “Required components of a COT monitoring visit,” p. 7).
- ✓ Patients on COT shall **receive all chronic pain management prescriptions from one physician and one pharmacy** wherever possible. Clinicians treating a patient on COT are expected to clarify—both among themselves and with the patient—which clinician holds primary prescribing responsibility. See “Opioid prescribing procedures,” p.13.
- ✓ Physicians prescribing opioids for chronic non-cancer pain shall have a one-time completion of at least 4 hours of **continuing medical education** relating to this topic. The State of Washington offers an [online CME](#) to help physicians comply with statewide rules.

# Managing Chronic Opioid Therapy

## Contraindications to opioid therapy

Use of opioid medications is contraindicated in patients with

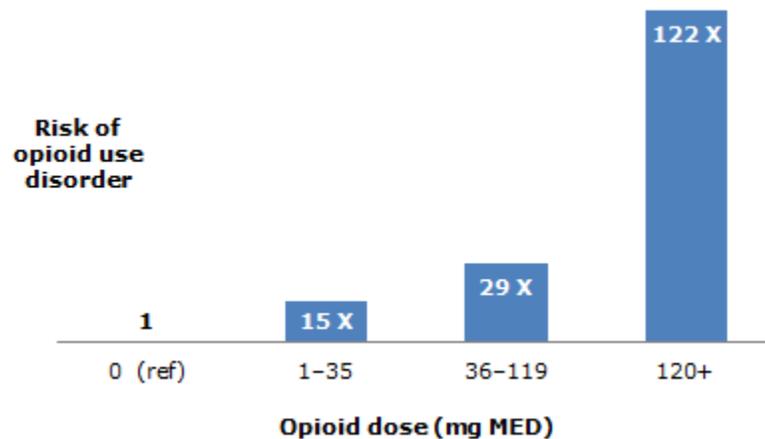
- Known opioid use disorder.
- History of opioid overdose.

See “Tapering and Discontinuing Opioids,” p. 10.

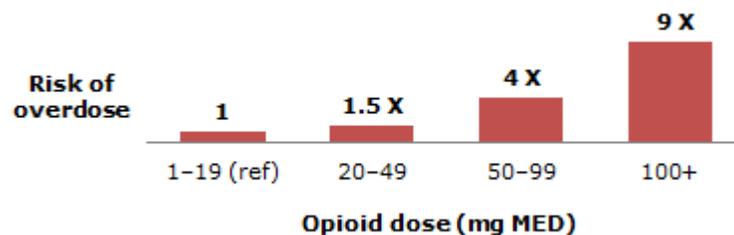
## Relationship between opioid dose and risk levels

When discussing a possible change in dose with a patient, explain that serious opioid-related risks increase sharply with higher doses.

**Opioid use disorder:** A person taking a relatively low dose of prescribed opioids is **15 times** as likely to develop opioid use disorder as a person who has not been prescribed opioids. The risk continues to rise with escalating doses; at high doses ( $\geq 120$  mg MED) of opioids, the person’s risk of developing OUD is **122 times** that of a person who has not been prescribed opioids. (Edlund 2014)



**Opioid overdose:** Similarly, a person taking  $\geq 100$  mg MED will be **9 times** as likely to overdose as a person taking  $< 20$  mg MED. (Dunn 2010) Note that approximately 1 overdose in 7 is fatal.



Use the SmartPhrase **.opioidrisks** for additional information on the medical risks of long-term opioid use.

## Risk stratification and intensity of monitoring

The intensity of monitoring is determined by the “patient attributes” in Table 1. Patients should be placed in the **highest-intensity group for which they meet at least one of the criteria**. For example, patients taking benzodiazepines should be in the high-intensity monitoring group even if they are on a relatively low dose of opioids (< 40 mg MED).

Table 1. Chronic opioid therapy patient groups	
Group	Patient attributes
High-intensity monitoring <sup>1</sup>	<ul style="list-style-type: none"> <li>• Taking ≥ 90 mg morphine equivalent dose (MED)/day <i>Note:</i> For patients taking ≥ 120 mg MED/day, referral to Physical Medicine &amp; Rehabilitation or a pain specialist is required.</li> <li>• Taking methadone or fentanyl</li> <li>• Taking sedative-hypnotic drugs (benzodiazepines, Z-drugs),<sup>2</sup> carisoprodol, or muscle relaxers concurrently</li> <li>• Using marijuana concurrently</li> <li>• Age 25 years or younger</li> <li>• High score (≥ 8) on the ORT</li> <li>• Repeated problems following opioid management treatment plan, such as:               <ul style="list-style-type: none"> <li>– Frequent early refill requests</li> <li>– Escalating dose without consulting with physician</li> <li>– Multiple emergency room/urgent care presentations for opioid treatment</li> <li>– Getting opioids from multiple prescribers</li> </ul> </li> </ul>
Moderate-intensity monitoring <sup>1</sup>	<ul style="list-style-type: none"> <li>• Taking between 40 mg and 89 mg MED/day</li> <li>• Moderate score (4–7) on the ORT</li> <li>• Relatively minor problems following opioid treatment plan</li> </ul>
Low-intensity monitoring	<ul style="list-style-type: none"> <li>• Taking &lt; 40 mg MED/day</li> <li>• Low score (0–3) on the ORT</li> <li>• Compliant with medication plan</li> </ul>
<p><sup>1</sup> Patients in the moderate- and high-intensity monitoring groups are at increased risk of opioid overdose and death from respiratory depression. Offer <b>naloxone</b> as preventive rescue medication for these patients. See “Prescribing naloxone,” p. 13.</p> <p><sup>2</sup> See the <a href="#">Benzodiazepine and Z-Drug Safety Guideline</a> and this 2016 <a href="#">FDA Safety Warning</a> on the risks of combining benzodiazepines with opioids.</p>	

## Frequency of monitoring visits

All patients on COT shall be monitored regularly, with the frequency of visits determined by the patient’s COT intensity group. These monitoring visits may be **in person, by phone, or by secure message**, based on clinical judgment. However, **all** patients on COT should be scheduled for an in-person appointment dedicated to COT monitoring at least annually.

The components of the COT monitoring visits are described on p. 7.

Table 2. Monitoring visit frequency by COT patient group	
Group	Frequency of visits
High-intensity monitoring	At least every 3 months.
Moderate-intensity monitoring	At least every 6 months.
Low-intensity monitoring	At least once a year.

## Required components of a COT monitoring visit

Every monitoring visit is an opportunity to improve safety for patients on COT, and to consider adjusting the Opioid Care Plan—including tapering or discontinuation of opioid therapy—based on changes in the patient’s conditions or comorbidities.

*Required at all COT monitoring visits:*

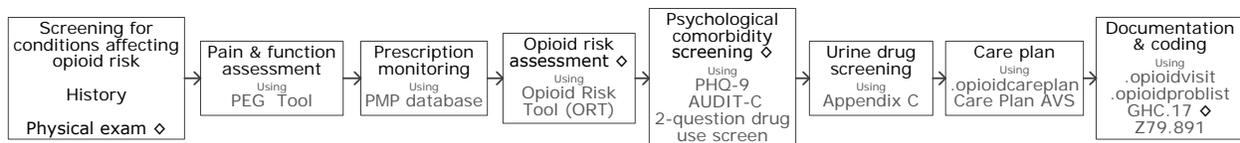
- ✓ Review medical history.
- ✓ Assess pain and function using PEG (Pain/Enjoyment/General function) Tool and document in flowsheet.
- ✓ Check Washington State Prescription Monitoring Program.
- ✓ Order urine drug screen.
- ✓ Document care plan in AVS using .opioidcareplan.
- ✓ Use .opioidproblast to update problem list.

*Required at initial COT monitoring visit only:*

- ✓ Conduct physical exam.
- ✓ Perform psychological comorbidity screening and document in chart.
- ✓ Complete Opioid Risk Tool and document in flowsheet.
- ✓ Add GHC.17 (Chronic Opioid Therapy care plan) to problem list.

For a patient’s **initial** COT monitoring visit (ongoing or new start), use SmartPhrase **.opioidvisit**, which includes all the components above.

For a patient’s **follow-up** COT monitoring visits, use either **.opioidvisit** or **.opioidmini**, which include all but the last four components above.



◊ Required at initial COT monitoring visit only

### Medical screening, history, and physical exam

- Screen for medical issues that affect opioid risk (e.g., pulmonary, cardiac, renal or hepatic disease; obstructive sleep apnea; pregnancy risk). See “Clinical indications for tapering or discontinuing opioid therapy,” p. 10.
- Obtain/review patient history.
- At the patient’s initial COT monitoring visit, conduct a physical exam.

### Pain and function assessment with the PEG (Pain/Enjoyment/General function) Tool

Continuation of chronic opioid therapy should be considered only when it is associated with **clinically meaningful improvement in function (CMIF)**. CMIF is defined as an improvement in pain **and** function of at least 30% as compared to the start of treatment or in response to a dose change. A decrease in pain intensity without improved function is not considered meaningful improvement except in very limited circumstances, such as catastrophic injuries (multiple trauma, spinal cord injury, etc.).

To assess patients’ ongoing response to COT, use the **PEG Tool** (Appendix D, p. 27), available as the SmartPhrase **.pegscore**. The PEG Tool is also available as a documentation flowsheet, review flowsheet, and secure message.

### Prescription monitoring

Check the patient’s record in the Washington State Prescription Monitoring Program database to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk. This is a central database that keeps track of schedule II–V medications that patients receive at any pharmacy in the state of Washington. Clinicians should check this database before continuing the use of COT for a patient. To sign up for access, see <http://www.wapmp.org>.

## Opioid risk assessment with the Opioid Risk Tool (ORT)

At the patient's initial COT monitoring visit, use the Opioid Risk Tool (Appendices A and B, pp. 19–20) to assess the patient's potential risks associated with COT. The ORT is a validated tool recommended by the Washington State AMDG.

## Psychological comorbidity screening

At the patient's initial COT monitoring visit, screen the patient for:

- **Alcohol use** with the AUDIT-C. (See the Adult Unhealthy Drinking Screening & Intervention Guideline.)
- **Drug use** with the two-question screen:
  1. How often have you used marijuana in the last year?
  2. How often have you used recreational drugs (such as heroin, cocaine, or methamphetamine) or used a prescription medicine for non-medical reasons in the last year?(Scale for both drug use questions: Never, Less than monthly, Monthly, Weekly, Almost daily, Daily)

*Note:* Annual screening for behavioral health issues is part of adult standard care.

## Urine drug screening

Urine drug screening (UDS) provides objective data regarding patients who are managing chronic pain and can be used to directly improve patient safety. For their safety, it is important that patients take opioids as prescribed, and this test helps assess whether they are doing that. UDS should also be ordered when seeing patients already on COT who are new to the health plan and have no record of recent UDS.

UDS is legally required, and its routine use helps to ensure that all patients on COT are treated equitably.

UDS is for medical purposes only. We do not collect samples for use in a court of law or for workplace testing.

Clinicians should have a discussion with the patient before the UDS that includes:

- The purpose of testing
- What will be screened for
- What results the patient expects
- Prescriptions or any other drugs the patient has taken
- Time and dose of last dose of opioids
- Actions that may be taken based on the results of the screen
- Possibility of cost to the patient

Patients should be notified that the results will become part of their permanent medical record.

For more detailed information on urine drug screening, see the [Resource Guide to Urine Drug Testing](#) (staff intranet) and Appendix C (p. 21).

## Coding

When documenting an encounter with a patient on COT, providers should include diagnosis codes for **both** the condition being treated with opioid medications **and** the long-term opioid treatment itself:

- **Diagnosis code for underlying condition, and**
- **Z79.891 Long-term (current) use of opioid analgesic**

When COT monitoring is the main reason for the visit, **Z79.891** should be used as the primary diagnosis, with the underlying condition as a secondary diagnosis. Conversely, when managing the underlying condition is the main reason for the visit—for example, when ordering physical therapy for a patient with chronic back pain—providers should document the **underlying condition** (chronic back pain) as the primary diagnosis, and Z79.891 as a secondary diagnosis.

**GHC.17** should be added to the problem list for all COT patients at the initial COT monitoring visit.

In the rare instances that providers are treating a patient with both a health problem requiring opioid therapy and a concurrent opioid use disorder, documentation should be clear that the opioids are being used to treat the indicated health problem and not as a treatment for the opioid use disorder. (For patients with an existing or suspected opioid use disorder, see “Recognizing substance use disorder,” below.)

## Recognizing substance use disorder

It is not uncommon for patients on COT to develop opioid use disorder (OUD) during their treatment. Assessment of these patients for signs or symptoms of substance use disorder is strongly encouraged.

Whenever OUD is suspected, ask the following two-question drug screen. The scale for both questions is: Never, Less than monthly, Monthly, Weekly, Almost daily, Daily.

1. How often have you used marijuana in the last year?
2. How often have you used recreational drugs (such as heroin, cocaine, or methamphetamine) or used a prescription medicine for non-medical purposes in the last year?

If the patient answers “Daily” to Question 1, or anything but “Never” to Question 2, use the Substance Use Disorder Symptom Checklist Flowsheet in Epic and/or contact the [Behavioral Health Services Mind Phone](#) (1-888-844-4662) for a consultation.

## Questions on the Substance Use Disorder Symptom Checklist

In the past 12 months:

1. Did you find that using the same amount of the substance has less effect than it used to or did you have to use more of the substance to get high or have more of the desired effect than when you started?
2. When you cut down or stopped using the substance did you have withdrawal symptoms? Did you use the substance or take other substances to avoid these symptoms?
3. When you have used the substance, did you use more or for longer than you planned to?
4. Have you wanted to or tried to cut back or stop using the substance, but been unable to do so?
5. Did you spend a lot of time obtaining the substance, using the substance or recovering from using the substance?
6. Did you continue to use the substance even though you knew or suspected it creates or worsens mental or physical problems?
7. Has using the substance interfered with your responsibilities at work, home or school?
8. Have you been high or intoxicated by the substance more than once in situations where it was dangerous such as driving a car or operating machinery?
9. Did you use the substance even though you knew or suspected it causes problems with your family or other people?
10. Did you experience strong desires or cravings to use the substance?
11. Did you spend less time working, enjoying hobbies or socializing with others because of your use of the substance?

**It is *illegal* for providers to treat opioid use disorders or opioid withdrawal with opioid medications except under very specific circumstances.** In outpatient settings, specific opioid medications may only be used by physicians with a special DEA waiver or by specially regulated opioid treatment programs to treat opioid use disorders.

# Tapering and Discontinuing Opioids

## Clinical indications for tapering or discontinuing opioid therapy

The following are **contraindications** to opioid use:

- Known opioid use disorder
- Previous opioid overdose

The following are **comorbid conditions** that increase the risk of adverse outcomes with opioid use. When discussing the risks and benefits of opioids with a patient, include these precautions, and **strongly encourage opioid tapering if any of these conditions are present**.

### Concurrent use of benzodiazepines: FDA boxed warning

The FDA has found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. In August 2016, the FDA added its strongest warnings to the labeling of prescription opioid pain and prescription opioid cough medicines and benzodiazepines. Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate.

See the [Benzodiazepine and Z-Drug Safety Guideline](#) and [FDA Boxed Warning](#).

- Concurrent use of sleeping pills, alcohol, muscle relaxers, THC, illicit drugs, sedating antihistamines
- Uncontrolled psychological issues, including depression, anxiety, or PTSD
- Age 65 years and over
- COPD
- CHF
- Cognitive concerns
- Osteoporosis
- Renal or hepatic insufficiency
- Severe obesity
- Obstructive sleep apnea
- Pregnancy: Because of possible risks to the fetus posed by opioid withdrawal, consult with an obstetric provider or other appropriate specialist.

In Epic, use **.opioidtaperletter** to generate a letter to patients on how to taper. The letter may then be sent to the patient via USPS mail or secure message.

In certain circumstances, it may be necessary to adjust or discontinue opioid therapy (see Table 3 on the following page).

In the following circumstances, it may be necessary to adjust or discontinue opioid therapy:

<b>Table 3. Clinical indications and methods for tapering opioid therapy</b>	
<b>Indication</b>	<b>Taper method</b>
<ul style="list-style-type: none"> <li>• Function and pain are not improved, or</li> <li>• Tolerance has developed with long-term opioid prescription, or</li> <li>• Comorbid conditions increase risk of complications.</li> </ul>	10% every 2–4 weeks
<ul style="list-style-type: none"> <li>• Medication adverse effects indicate risks are greater than benefit, or</li> <li>• Morphine equivalent dose exceeds recommended threshold, or</li> <li>• Comorbid conditions increase risk of complications.</li> </ul>	10% per week
<ul style="list-style-type: none"> <li>• Urine drug screen is consistent with substance abuse concerns, or</li> <li>• Patient’s behavior suggests possible misuse or diversion of medication. Such behaviors might include:               <ul style="list-style-type: none"> <li>○ Selling prescription drugs</li> <li>○ Forging prescriptions</li> <li>○ Stealing or borrowing drugs</li> <li>○ Frequently losing prescriptions</li> <li>○ Aggressive demand for opioids</li> <li>○ Injecting oral/topical opioids</li> <li>○ Unsanctioned use of opioids</li> <li>○ Unsanctioned dose escalation</li> <li>○ Concurrent use of illicit drugs</li> <li>○ Getting opioids from multiple prescribers</li> <li>○ Recurring emergency department visits for chronic pain management</li> </ul> </li> </ul>	<p>Rapid discontinuation: 15–33% per day over 3–7 days</p> <p>and/or</p> <p>Refer patient for chemical dependency or addiction counseling. (See Referral Criteria, p. 16.)</p> <p>See Treating opioid withdrawal symptoms on following page.</p>

## Treating opioid withdrawal symptoms

When opioids are rapidly discontinued (see Table 3, above) or stopped immediately, withdrawal symptoms can occur. The typical time course for symptom development depends on the particular opioid used by the patient.

- Short-acting opioids (e.g., heroin or oxycodone): Withdrawal symptoms begin 8–12 hours after last use and peak 48–72 hours after last use.
- Long-acting opioids (e.g., methadone or buprenorphine): Withdrawal symptoms begin more gradually, with a few symptoms in the first 24–48 hours, a peak in symptoms 3–5 days after last use, and some symptoms continuing for up to a few weeks.

While opioid withdrawal is unpleasant, it is not dangerous to patients. Medications for withdrawal symptoms are in Table 4.

<b>Table 4. Medications used to treat symptoms during gradual opioid taper</b>		
<b>Target symptoms</b>	<b>Medication</b>	<b>Dosing</b>
Hypertension, tremors, sweats, anxiety, restlessness	Clonidine <sup>1</sup>	0.1 mg three times daily as needed
Anxiety, restlessness	Hydroxyzine <sup>2</sup> or Diphenhydramine <sup>2</sup>	25 mg every 6 hours as needed
Insomnia	Hydroxyzine <sup>2</sup> or Diphenhydramine <sup>2</sup>	25–50 mg daily at bedtime as needed
Nausea/vomiting	Promethazine <sup>2</sup>	25 mg every 6 hours as needed
	Metoclopramide <sup>2</sup>	10 mg every 6 hours as needed
Dyspepsia	Calcium carbonate	500 mg 1–2 tabs every 8 hours as needed
	Mylanta, Milk of Magnesia	Follow package instructions.
Pain, fever	Acetaminophen (Tylenol)	500 mg every 4 hours (not to exceed 3 g/24 hours)
	Ibuprofen	400 mg every 4 hours as needed
Diarrhea	Loperamide <sup>2</sup>	4 mg initially, then 2 mg every loose stool as needed; maximum 16 mg/day
Muscle spasm	Methocarbamol <sup>2</sup>	1,000 mg every 6 hours as needed
<sup>1</sup> Clonidine is not FDA-approved for this use, although evidence supports use in this setting. This guideline recommends clonidine as the first-line agent, as it is effective in many patients. As a non-opioid treatment option, it is readily available statewide and does not have extra restrictions on prescribing. Monitor blood pressure and pulse. Dosing of clonidine depends on whether patient is acutely withdrawing or gradually being tapered.		
<sup>2</sup> These are high-risk medications for the elderly. Please consider alternatives for patients aged 64 and older.		

# Minimizing Risks When Continuing to Prescribe COT

This guideline seeks to balance the appropriate use of opioid therapy in chronic non-cancer pain against its potential harms.

- Opioid therapy is continued only when the expected benefits—such as reduced pain and clinically meaningful improvement in function (as measured with the PEG Tool)—are expected to outweigh the risks of overdose, opioid use disorder, and other opioid-related harms.
- Opioid therapy is prescribed at the lowest necessary dose and for the shortest duration.
- Clinicians who manage patients on COT are skilled and knowledgeable in both the principles of opioid prescribing and the assessment and management of risks—including the development of opioid use disorder—associated with opioid use.
- Clinicians who manage patients on COT routinely integrate psychotherapeutic interventions, functional restoration, interdisciplinary treatment as needed and available, and other non-opioid therapies. Pain is a normal sensation. Acceptance of chronic pain and focus on functional goals improves quality of life.
- The Centers for Disease Control and Prevention has found insufficient evidence to determine the long-term benefits of opioid therapy for chronic pain, and has found an increased risk for serious harms related to long-term opioid therapy that appears to be dose-dependent. (Dowell 2016)

## Prescribing naloxone as preventive rescue medication

Naloxone is an opioid antagonist that may be used to reverse the symptoms of opioid overdose (including respiratory depression) after a known or suspected opioid overdose. *Naloxone does not replace emergency medical care.*

**Offer to prescribe naloxone as a preventive rescue medication for patients (and their family members) in the moderate- and high-intensity groups**—those who are taking opioid therapy  $\geq 40$  mg MED per day or have other risk factors for opioid overdose as defined in Table 1, p. 6.

The preferred naloxone product at Kaiser Foundation Health Plan of Washington is Narcan nasal spray.

Counsel family members or other personal contacts who are in a position to assist the patient who is at risk of opioid-related overdose.

### Resources

Pharmacy [patient handout](#) on naloxone nasal spray (staff intranet). Use SmartPhrase **.avsnaloxone**. Opioid overdose prevention education: [www.stopoverdose.org](http://www.stopoverdose.org)

## Opioid prescribing procedures

Chronic non-cancer pain patients should receive all chronic pain management prescriptions from one physician and one pharmacy whenever possible. Clinicians involved in treating a patient on COT are expected to clarify—both among themselves and with the patient—which clinician holds primary responsibility for prescribing. Cross-coverage by another Primary Care provider is included as an extension of the primary prescribing clinician.

Before writing a prescription:

- Calculate and document the total morphine equivalent dose (MED); doing this can help assess the magnitude of seemingly small incremental dosage changes over time. See “Morphine equivalent dosing,” below.
- Calculate and document the total acetaminophen dose, including prescribed and over-the-counter.

When writing prescriptions, provide explicit directions:

- Order medication in multiples of 7 days and include “to last \_\_\_ days.”
- Consider setting up refills on Tuesday through Thursday so that they don’t fall on a Monday or Friday, when patients and/or providers are more likely to be on vacation.

- Providers may prescribe up to 3 months (84 days) of medication for patients who are stable.
- Provide specific patient instructions (e.g., schedule for taking).

**Do not** prescribe extended-release/long-acting opioid medication on an as-needed basis.

- Food and Drug Administration (FDA) labels state that extended-release and long-acting opioid analgesics are indicated “for the management of pain severe enough to require daily, around-the-clock opioid treatment and for which alternative treatments are inadequate.” The labels emphasize first considering potentially less-addictive measures.
- Limitations of use: Due to the greater risks of overdose and death with extended-release formulations, their use should be reserved for patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, are not tolerated, or provide inadequate or insufficient pain management. ([FDA news release](#) 2013)
- For patients aged 65 years and older, short-acting opioids are preferable, as metabolism of medications slows with age. (AMDG 2015)

**Do not** initiate extended-release/long-acting opioid medication in opioid-naïve patients.

## Morphine equivalent dosing (MED)

An [electronic MED calculator](#) is available on the Agency Medical Directors’ Group web site.

### Equianalgesic dosing and cross-tolerance

All conversions between opioids are estimates generally based on “equianalgesic dosing” (ED). Patient response to these EDs can vary widely, due primarily to genetic factors and incomplete cross-tolerance. **It is recommended that, after the appropriate conversion dose is calculated, it be reduced by 25–50% to ensure safety.**

- Reduce opioid dose by 30–50% to accommodate for unknown cross-tolerance and titrate to goal.
- The wide variation among individuals is multifactorial and poorly understood.
- Incomplete cross-tolerance can lead to greater than anticipated potency in a new opioid, even in the same class of analgesic.
- Monitor clinical response and adverse effects.

**Table 5. Morphine equivalent dosing (MED) for selected opioids <sup>1</sup>**

Opioid	Approximate equianalgesic dose (oral and transdermal) <sup>2</sup>
Morphine (reference)	30 mg
Codeine	200 mg
Fentanyl transdermal	12.5 mcg/hr
Hydrocodone	30 mg
Hydromorphone	7.5 mg
Oxycodone	20 mg
Oxymorphone	10 mg
Tramadol	300 mg

<sup>1</sup> Agency Medical Directors’ Group (AMDG) 2015.

<sup>2</sup> Adapted from Von Korff 2008 and FDA labeling.

## Methadone

Additionally, methadone has unique characteristics that make it difficult to translate dose to MED. Methadone exhibits a non-linear relationship due to its long half-life and accumulates with chronic dosing. You may see a dramatic increase in MED depending on the dose. The conversion factors for methadone in the AMDG calculator are based on chronic dosing and as follows:

**Table 6. Methadone conversion factors<sup>1</sup>**

Methadone	Factor
≤ 20 mg/day	4
21–40 mg/day	8
41–60 mg/day	10
> 60 mg/day	12

<sup>1</sup> Ayonrinde 2000

## Adverse effects of opioids

**Serious** adverse effects may include:

- **Slowed breathing that can cause death.** This is more likely for patients who:
  - Have sleep apnea or chronic lung disease,
  - Are on higher opioid doses,
  - Take more medicine than prescribed, or
  - Mix opioids with alcohol, other prescription medicines (such as sleep aids, muscle relaxers, and tranquilizers), or street drugs.See also “Prescribing naloxone as preventive rescue medication,” p. 13.
- **Sedation (sleepiness and sluggishness)** can cloud patients’ judgment and slow their reaction time, putting them at increased risk for falls and accidents while driving, using tools, or operating heavy equipment. Driving while on opioids may be considered driving under the influence (DUI).
- **Babies born to mothers taking opioids will be dependent on opioids at birth.** Women who are trying to get pregnant should not take opioids. Women who become pregnant while taking opioids should consult with their physician to make a plan regarding their medication.
- **Physical dependence, tolerance, or addiction to opioids.** Patients with *physical dependence* will experience withdrawal if they stop suddenly. Patients with *tolerance* need to take more of the medicine to get the same effect. Patients with *addiction* are not able to control their use of opioids even if they want to, which may result in harmful outcomes. See “Recognizing substance use disorder,” p. 9.

**Common** adverse effects may include:

- Constipation
- Depression
- Fatigue
- Itching (a side effect and not an allergic reaction)
- Nausea or vomiting
- Decreased sex drive (decreased testosterone)
- Low blood pressure
- Difficulty with urination
- Insomnia
- Increased sensitivity to pain (hyperalgesia)
- Impaired immune system

## Referral Criteria

Table 7. Referral recommendations for patients on COT for chronic non-cancer pain	
Reason for referral	Specialty
<ul style="list-style-type: none"> <li>• Dose increase to 120 mg MED or higher per day (specialty consultation <i>required</i>)</li> <li>• Help with tapering/discontinuing opioid medication</li> <li>• Comprehensive rehabilitation evaluation</li> </ul>	Physical Medicine & Rehabilitation or pain specialist <sup>1</sup>
<ul style="list-style-type: none"> <li>• Psychiatric illness or symptoms complicating treatment of chronic pain</li> <li>• Possible undiagnosed psychiatric condition complicating treatment of chronic pain</li> </ul>	Behavioral Health
<ul style="list-style-type: none"> <li>• Urine drug screen positive for alcohol, sedative, cocaine or methamphetamine use</li> <li>• Patient request for help with addiction</li> <li>• Possible buprenorphine (Suboxone) treatment for opioid use disorder</li> </ul>	Chemical Dependency: Contact Behavioral Health Access to arrange patient access to community programs and resources.
<ul style="list-style-type: none"> <li>• Concern about substance use disorder</li> <li>• Difficulty adhering to opioid care plan</li> <li>• Problematic use of medications other than opioids</li> </ul>	Addiction Medicine: one-time consult (western Washington only)
<sup>1</sup> Other pain specialists may include rheumatologists, neurologists, and anesthesiologists. See WAC-256-919-863 in Appendix E for more information.	

# Evidence and References

The guideline team adopted the recommendations of:

Washington State Agency Medical Directors Group (AMDG). Interagency Guideline on Prescribing Opioids for Pain. Olympia, WA: Washington State Agency Medical Directors' Group; 2015.  
<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

Dowell D, Haegerich TM, Chou R. Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep* 2016;65(No. RR-1):1–49. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>.

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Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med*. 2010;152:85–92.

Edlund MJ, Martin BC, Russo JE, DeVries A, Braden JB, Sullivan MD. The role of opioid prescription in incident opioid abuse and dependence among individuals with chronic noncancer pain: the role of opioid prescription. *Clin J Pain*. 2014;30:557–564.

Food and Drug Administration. *FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning*. Silver Spring, MD: U.S. Food and Drug Administration; August 31, 2016.

Food and Drug Administration. *FDA announces safety labeling changes and postmarket study requirements for extended-release and long-acting opioid analgesics* [news release]. Silver Spring, MD: U.S. Food and Drug Administration; September 10, 2013.

Von Korff M, Saunders K, Thomas RG, et al. De facto long-term opioid therapy for noncancer pain. *Clin J Pain*. 2008 Jul-Aug;24(6):521–527.

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# Guideline Development Process and Team

## Development process

This guideline was adapted from externally developed evidence-based guidelines and organizations that establish the community standards for chronic opioid therapy for chronic non-cancer pain. The guideline team reviewed additional evidence using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis. For details, see Evidence and References.

This edition of the guideline was approved for publication by the Guideline Oversight Group in September 2016.

## Team

The following specialties were represented on the development and/or update team: behavioral health, clinical laboratory, family medicine, pharmacy, and physical medicine and rehabilitation.

Clinician lead: [Angie Sparks, MD](#), Medical Director, Clinical Knowledge Development & Support  
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## Disclosure of conflict of interest

Kaiser Permanente requires that team members participating on a guideline team disclose and resolve all potential conflicts of interest that arise from financial relationships between a guideline team member or guideline team member's spouse or partner and any commercial interests or proprietary entity that provides or produces health care-related products and/or services relevant to the content of the guideline.

Team members listed above have disclosed that their participation on the Chronic Opioid Therapy Safety Guideline team includes no promotion of any commercial products or services, and that they have no relationships with commercial entities to report.

## Appendix A.

# Opioid Risk Tool (ORT)

Date \_\_

Patient Name \_\_

### OPIOID RISK TOOL

		Mark each box that applies	Item score if female	Item score if male
1. Family History of Substance Abuse	Alcohol	<input type="checkbox"/>	1	3
	Illegal Drugs	<input type="checkbox"/>	2	3
	Prescription Drugs	<input type="checkbox"/>	4	4
2. Personal History of Substance Abuse	Alcohol	<input type="checkbox"/>	3	3
	Illegal Drugs	<input type="checkbox"/>	4	4
	Prescription Drugs	<input type="checkbox"/>	5	5
3. <b>Age</b> (Mark box if 16–45)		<input type="checkbox"/>	1	1
4. History of Preadolescent Sexual Abuse		<input type="checkbox"/>	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	<input type="checkbox"/>	2	2
	Depression	<input type="checkbox"/>	1	1
		TOTAL	_____	_____

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.

## Appendix B.

# Opioid Risk Tool (ORT) Scoring

Total Score Risk Category

Low Risk 0–3

Moderate Risk 4–7

High Risk  $\geq 8$

## Notes

- Administration: The ORT **must** be administered by the provider and not by another member of the care team.
- Follow-up: For patients answering “**yes**” to **question 4** (regarding pre-adolescent sexual abuse), providers should express empathy and consider screening for post-traumatic stress disorder (PTSD) using the following questions. If the patient answers “yes” to any of the four questions, consider referral to Behavioral Health Services.

### **Primary Care PTSD screening questions**

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you:

- Have had nightmares about it or thought about it when you did not want to?
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?



# GroupHealth

## LABORATORY SERVICES

Resource Guide Pain Management Urine Drug Testing (6 pp)  
March 2015

### General information:

Urine drug testing (UDT) is useful in monitoring opiate use in patients in a pain management program and other drugs in patients enrolled in drug rehabilitation. Patients starting a program should be carefully counselled on the overall treatment goals and the purpose of drug monitoring. It is essential to document all medications that patient is taking (including over the counter medications, herbs, naturopathic remedies) before the testing to determine which test results are appropriate and those that are not. This memo is designed to give you quick information, including ordering (Table 1), detection limits, retention times (Table 2) and a results guide (Table 3).

**What's included:** amphetamines, barbituates, benzodiazepines, opioids (codeine, morphine, methadone and others), oxycodone, tricyclic antidepressants, cocaine, marijuana, methamphetamine, phencyclidine

**What must be ordered separately:** alcohol, fentanyl,

A fresh urine sample is collected by either the physician's office or the lab and immediately labeled. The laboratory will not accept unlabeled specimens or specimens brought from home. The lab inspects the sample for unusual color, foaming or odor, since patients may use water, bleach, vinegar, detergent, etc. to alter the specimen.

**Dilution:** A random urine creatinine is performed. If the value less than 20, it indicates the sample was diluted and the lab can only report positive results. Negative results will be reported as "too dilute". Diuretics can result in a dilute urine.

Group Health uses a 2 step process for pain management testing.

1. Urine drug screen. See table 2 for details.
2. Confirmation testing. Method is by GC/MS/MS. This is the gold standard for specificity and sensitivity. It is used to clarify positive urine drug screen and to screen for opioids in the event of a negative urine drug screen.

Urine drug testing at Group Health is for medical management only. Test results are not acceptable as evidence in a court of law, employment screening or for court ordered testing. Exceptions to this are drug tests on mothers and newborns.

Ordering:

You can order UDT panels with reflex screening confirmation testing on positive results (80100.015). This convenience allows you to request confirmation testing at the time of order, eliminating the need to order after the test results come back.

The UDT panel without confirmation testing (80100.024) is available for those patients who do not need confirmation testing.

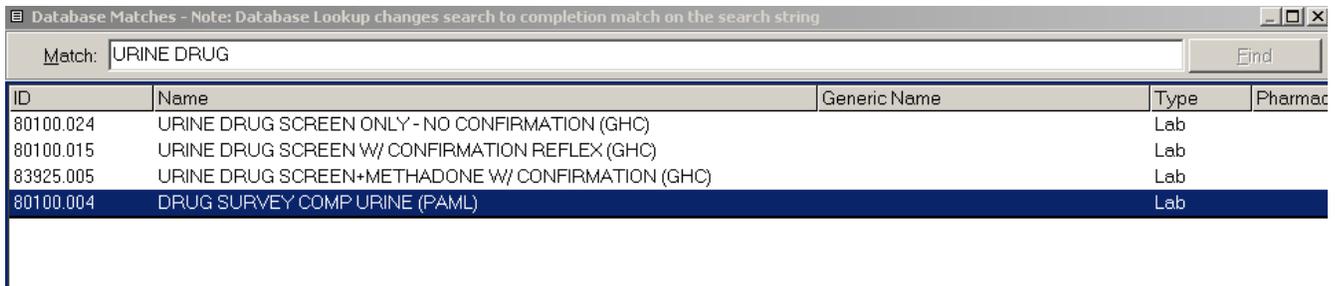
Confirmation eliminates any question of a false positive or false negative drug screen result. It should be ordered whenever there are important consequences connected with a positive result.

All UDT screens (80100.015) on newborn, ED and UC patients include automatic reflex confirmation.

Please review the following pages for the EPIC screen shot and three informational tables. This information will be posted on the Clinical Laboratory website ([http://incontext.ghc.org/clinical/clin\\_lab/clabhome.html](http://incontext.ghc.org/clinical/clin_lab/clabhome.html)) for future reference.

Questions/Comments? Please e-mail Kim Riddell, M.D.

## EPIC SCREEN SHOT



The screenshot shows a window titled "Database Matches - Note: Database Lookup changes search to completion match on the search string". The search criteria is "URINE DRUG". The results are displayed in a table with the following columns: ID, Name, Generic Name, Type, and Pharmacology. The results are as follows:

ID	Name	Generic Name	Type	Pharmacology
80100.024	URINE DRUG SCREEN ONLY - NO CONFIRMATION (GHC)		Lab	
80100.015	URINE DRUG SCREEN W/ CONFIRMATION REFLEX (GHC)		Lab	
83925.005	URINE DRUG SCREEN+METHADONE W/ CONFIRMATION (GHC)		Lab	
80100.004	DRUG SURVEY COMP URINE (PAML)		Lab	

**TABLE 1 Ordering options**

<b>GHC Drug Screens:</b>	<b>EPIC code:</b>
UDS screen; Positive results reflex to confirmation* <i>* TCA positive specimens: No urine confirmation test available. If confirmation is required a separate serum specimen must be collected. A comment will be appended on all positive results with the order procedure.</i>	80100.015
UDS screen; No reflex to confirmation (unless requested by provider after test performed)	80100.024
Urine Alcohol (separate test)	80101.010
Bupremorphone screen	
Fentanyl	

**TABLE 2: Detection limits and retention times**

<b>Drug tested:</b>	<b>Abbreviation</b>	<b>Detection limit (ng/mL)</b>	<b>Detection Time</b>
Alcohol	ALC-U	10 mg/dL	7-12 h
Amphetamines and methamphetamine	AMP	1000	3 – 5 days
Barbiturates Short acting Long acting (eg phenobarbital)	BAR	300	4 – 6 days up to 30 days
Benzodiazepines Short acting (eg	BZO	300	1 – 7 days

lorazepam) Long acting (eg diazepam)			Up to 30 days
Cocaine metabolites	COC	300	2 – 4 days
Marijuana (Cannabinoids) Single use Moderate use Daily use Long term heavy smoker	THC	50	3 days 5 -7 days 10-15 days 30 days
Methylenedioxy-methamphetamine	MDMA	500	1 – 3
Methamphetamine	MET	1000	3-5
Methadone	MTD	300	2-4 days
Opiates (heroin, morphine, codeine, methadone) Propoxyphene	OPI	300	2 – 3 days  6 h to 2 days
Oxycodone Intermediate release Timed release	OXY	100	0 – 1.5 days 2-4 days
Phencyclidine	PCP	25	0 – 10 days
Tricyclics	TCA	1000	Varies

**TABLE 3: Interpretation Guide**

This tool will cover many common situations, but if you still have questions, send a secure message to either Dr. Riddell or Lab Customer Service.

**Drug dose CANNOT be extrapolated from results!**

<b>Prescription:</b> <i>TIP: Ask and document over the counter drug use prior to testing.</i>	<b>Expected results:</b> <i>Either Urine drug screen and/or confirmation by GC-MS</i>	<b>Unexpected results:</b> <i>Either Urine drug screen and/or confirmation by GC-MS</i>
Codeine	Screen: Positive opiates Confirmation: codeine, morphine, hydromorphone, hydrocodone (<11%)	
Hydrocodone	Screen: Positive opiates Confirmation: Hydrocodone, hydromorphone, dihydrocodeine	
Morphine	Screen: Positive opioids Confirmation: Morphine, hydromorphone (<2.5%)	Codeine and codeine derivatives, oxycodone and derivatives including oxymorphone. (See impurities below)
Hydromorphone	Screen: Positive opioids Confirmation: Hydromorphone, hydromorphol	Hydrocodone-NOT a hydromorphone metabolite (See impurities below)
Oxycodone	Screen: Positive oxycodone Confirmation: Oxycodone and oxymorphone Positive result for opiate screen only at very high levels.	
Oxymorphone	Screen: Positive opiate Confirmation: 6-hydroxy-oxymorphone	Oxycodone— NOT a oxycodone metabolite (See impurities below)
Heroin	Often not detected due to very short half life (minutes). If 6-acetylmorphine and morphine is reported on confirmation screen, this is evidence of heroin use..	
No history given		Methadone, cocaine, oxycodone, marijuana. Diagnostic because they are not metabolites of other drugs

Lidocaine, benzocaine, other "caine" meds	Negative urine screen for cocaine	
Passive marijuana smoke inhalation		Unlikely to cause a positive urine screen
Ingestion of coca leaves, hemp seeds		Unlikely to cause a positive urine screen
Ingestion of poppy seeds	Positive opiate	
Inhalation of Vick's Vapo-rub	Positive methamphetamine in urine drug screen. A confirmatory GC/MS level ABOVE 200 ng/mL is consistent with illicit drug use	
Heroin	Often not detected due to very short half life (minutes). If 6-acetylmorphine and morphine is reported on confirmation screen, this is evidence of heroin use..	
Clonazepam (Klonopin)	7-aminoclonazepam	
Prazepam	Nordiaxepam, oxazepam or both	
Diazepam (Valium)	Nordiazepam, oxazepam, temazepam (any combination)	
Temazepam (Restoril)	Oxazepam	
Ephedrine, pseudoephedrine	Amphetamine	
Ritalin (methylphenidate)	Negative urine screen for amphetamine	
Methadone (must order separately)	Negative urine screen for opiates	
HIV patient taking efavirinez	False positive urine screen for benzodiazepine or THC. Confirmation testing should be negative for benzodiazepine	
Manufacturing impurities in prescription	eg. hydrocodone in an oxycodone or hydromorphone prescription codeine in a morphine prescription. The amount should be <b>tiny</b> compared to parent drug and major metabolite	

## Appendix D.

# Pain intensity, interference with Enjoyment of life, and interference with General activity (PEG) Tool

## PEG Tool

1. What number best describes your **pain on average** in the past week?  
0      1      2      3      4      5      6      7      8      9      10  
No pain      Pain as bad as you can imagine
2. What number best describes how, during the past week, pain has interfered with your **enjoyment of life**?  
0      1      2      3      4      5      6      7      8      9      10  
Does not interfere      Completely interferes
3. What number best describes how, during the past week, pain has interfered with your **general activity**?  
0      1      2      3      4      5      6      7      8      9      10  
Does not interfere      Completely interferes

## Washington Administrative Code WAC 246-919-850–863: Pain management

Available online at <http://app.leg.wa.gov/wac/default.aspx?cite=246-919-850>

### **WAC 246-919-850: Pain management—Intent.**

These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

The Washington state medical quality assurance commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this rule, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this rule has been developed to clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The commission recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or noncancer origins. The commission will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and nonpharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The commission is obligated under the laws of the state of Washington to protect the public health and safety. The commission recognizes that the use of opioid analgesics for other than legitimate medical purposes poses a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The commission will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work-related factors.

These rules are designed to assist practitioners in providing appropriate medical care for patients. They are not inflexible rules or rigid practice requirements and are not intended, nor should they be used, to establish a legal standard of care outside the context of the medical quality assurance committee's jurisdiction.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the practitioner based on all the circumstances presented. Thus, an approach that differs from the rules, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. However, a practitioner who employs an approach substantially different from these rules is advised to document in the patient record information sufficient to justify the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation, and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment.

Therefore, it should be recognized that adherence to these rules will not assure an accurate diagnosis or a successful outcome. The sole purpose of these rules is to assist practitioners in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

#### **WAC 246-919-851: Exclusions.**

The rules adopted under WAC 246-919-850 through 246-919-863 do not apply:

- (1) To the provision of palliative, hospice, or other end-of-life care; or
- (2) To the management of acute pain caused by an injury or surgical procedure.

#### **WAC 246-919-852: Definitions.**

The definitions in WAC 246-919-850 through 246-919-863 apply unless the context clearly requires otherwise.

- (1) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It is generally time-limited, often less than three months in duration, and usually less than six months.
- (2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:
  - (a) Impaired control over drug use;
  - (b) Craving;
  - (c) Compulsive use; or
  - (d) Continued use despite harm.
- (3) "Chronic noncancer pain" means a state in which noncancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
- (4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.
- (5) "Episodic care" means medical care provided by a practitioner other than the designated primary care practitioner in the acute care setting, for example, urgent care or emergency department.

(6) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.

(7) "Morphine equivalent dose" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(8) "Multidisciplinary pain clinic" means a clinic or office that provides comprehensive pain management and includes care provided by multiple available disciplines or treatment modalities, for example, medical care through physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, and physical therapy, occupational therapy, or other complementary therapies.

(9) "Palliative" means care that improves the quality of life of patients and their families facing life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

### **WAC 246-919-853: Patient evaluation.**

The physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.

(1) The patient's health history shall include:

- (a) Current and past treatments for pain;
- (b) Comorbidities; and
- (c) Any substance abuse.

(2) The patient's health history should include:

- (a) A review of any available prescription monitoring program or emergency department-based information exchange; and
- (b) Any relevant information from a pharmacist provided to a physician.

(3) The initial patient evaluation shall include:

- (a) Physical examination;
- (b) The nature and intensity of the pain;
- (c) The effect of the pain on physical and psychological function;
- (d) Medications including indication(s), date, type, dosage, and quantity prescribed;
- (e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:
  - (i) History of addiction;
  - (ii) Abuse or aberrant behavior regarding opioid use;
  - (iii) Psychiatric conditions;
  - (iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;
  - (v) Poorly controlled depression or anxiety;
  - (vi) Evidence or risk of significant adverse events, including falls or fractures;
  - (vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;
  - (viii) Repeated visits to emergency departments seeking opioids;
  - (ix) History of sleep apnea or other respiratory risk factors;
  - (x) Possible or current pregnancy; and
  - (xi) History of allergies or intolerances.

(4) The initial patient evaluation should include:

- (a) Any available diagnostic, therapeutic, and laboratory results; and
- (b) Any available consultations.

(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:

- (a) The diagnosis, treatment plan, and objectives;
- (b) Documentation of the presence of one or more recognized indications for the use of pain medication;

- (c) Documentation of any medication prescribed;
- (d) Results of periodic reviews;
- (e) Any written agreements for treatment between the patient and the physician; and
- (f) The physician's instructions to the patient.

**WAC 246-919-854: Treatment plan.**

(1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall include, at a minimum:

- (a) Any change in pain relief;
- (b) Any change in physical and psychosocial function; and
- (c) Additional diagnostic evaluations or other planned treatments.

(2) After treatment begins the physician should adjust drug therapy to the individual health needs of the patient. The physician shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The physician shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

**WAC 246-919-855: Informed consent.**

The physician shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

**WAC 246-919-856: Written agreement for treatment.**

Chronic noncancer pain patients should receive all chronic pain management prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing physician shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:

- (1) The patient's agreement to provide biological samples for urine/serum medical level screening when requested by the physician;
- (2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;
- (3) Reasons for which drug therapy may be discontinued (e.g., violation of agreement);
- (4) The requirement that all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;
- (5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;
- (6) A written authorization for:
  - (a) The physician to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies; and
  - (b) Other practitioners to report violations of the agreement back to the physician;
- (7) A written authorization that the physician may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;
- (8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;
- (9) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and
- (10) Acknowledgment that if the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

**WAC 246-919-857: Periodic review.**

The physician shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

- (1) During the periodic review, the physician shall determine:
  - (a) Patient's compliance with any medication treatment plan;
  - (b) If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers; and
  - (c) If continuation or modification of medications for pain management treatment is necessary based on the physician's evaluation of progress towards treatment objectives.
- (2) The physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The physician shall consider tapering, changing, or discontinuing treatment when:
  - (a) Function or pain does not improve after a trial period;
  - (b) There is evidence of significant adverse effects;
  - (c) Other treatment modalities are indicated; or
  - (d) There is evidence of misuse, addiction, or diversion.
- (3) The physician should periodically review information from any available prescription monitoring program or emergency department-based information exchange.
- (4) The physician should periodically review any relevant information from a pharmacist provided to the physician.

**WAC 246-919-858: Long-acting opioids, including methadone.**

Long-acting opioids, including methadone, should only be prescribed by a physician who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. The physician prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic.

**WAC 246-919-859: Episodic care.**

- (1) When evaluating patients for episodic care, such as emergency or urgent care, the physician should review any available prescription monitoring program, emergency department-based information exchange, or other tracking system.
- (2) Episodic care practitioners should avoid providing opioids for chronic pain management. However, if opioids are provided, the practitioner should limit the use of opioids for a chronic noncancer pain patient to the minimum amount necessary to control the pain until the patient can receive care from a primary care practitioner.
- (3) Prescriptions for opioids written by an episodic care practitioner shall include indications for use or the International Classification of Diseases (ICD) code and shall be written to require photo identification of the person picking up the prescription in order to fill.
- (4) If a patient has signed a written agreement for treatment and has provided a written authorization to release the agreement under WAC 246-919-856(6) to episodic care practitioners, then the episodic care practitioner should report known violations of the agreement back to the patient's treatment practitioner who provided the agreement for treatment.

**WAC 246-919-860: Consultation—Recommendations and requirements.**

- (1) The physician shall consider, and document the consideration, referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance

abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED)(oral). In the event a physician prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-919-863 is required, unless the consultation is exempted under WAC 246-919-861 or 246-919-862. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.

(a) The mandatory consultation shall consist of at least one of the following:

- (i) An office visit with the patient and the pain management specialist;
- (ii) A telephone consultation between the pain management specialist and the physician;
- (iii) An electronic consultation between the pain management specialist and the physician; or
- (iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist.

(b) A physician shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the physician, the physician shall maintain it as part of the patient record.

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-919-850 through 246-919-863, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

**WAC 246-919-861: Consultation—Exemptions for exigent and special circumstances.**

A physician is not required to consult with a pain management specialist as described in WAC 246-919-863 when he or she has documented adherence to all standards of practice as defined in WAC 246-919-850 through 246-919-863 and when any one or more of the following conditions apply:

- (1) The patient is following a tapering schedule;
- (2) The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with expected return to or below their baseline dosage level; or
- (3) The physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or
- (4) The physician documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

**WAC 246-919-862: Consultation—Exemptions for the physician.**

The physician is exempt from the consultation requirement in WAC 246-919-860 if one or more of the following qualifications are met:

- (1) The physician is a pain management specialist under WAC 246-919-863; or
- (2) The physician has successfully completed, within the last two years, a minimum of twelve (Category I) continuing education hours on chronic pain management with at least two of these hours dedicated to long-acting opioids; or
- (3) The physician is a pain management practitioner working in a multidisciplinary chronic pain treatment center, or a multidisciplinary academic research facility; or
- (4) The physician has a minimum three years of clinical experience in a chronic pain management setting, and at least thirty percent of his or her current practice is the direct provision of pain management care.

**WAC 246-919-863: Pain management specialist.**

A pain management specialist shall meet one or more of the following qualifications:

(1) If a physician or osteopathic physician:

- (a) Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or
- (b) Has a subspecialty certificate in pain medicine by an ABMS-approved board; or
- (c) Has a certification of added qualification in pain management by the AOA; or
- (d) A minimum of three years of clinical experience in a chronic pain management care setting; and
  - (i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and
  - (ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for physicians or three years for osteopathic physicians; and
  - (iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.

(3) If an advanced registered nurse practitioner (ARNP):

- (a) A minimum of three years of clinical experience in a chronic pain management care setting;
- (b) Credentialed in pain management by the Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity;
- (c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and
- (d) At least thirty percent of the ARNP's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(4) If a podiatric physician:

- (a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or
- (b) A minimum of three years of clinical experience in a chronic pain management care setting; and
- (c) Credentialed in pain management by the Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity; and
- (d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.

## Appendix F.

# Epic SmartPhrases for COT

### .opioidvisit 419001

#### Subjective

@NAME@ is a @AGE@ @SEX@ who is here for initiation/monitoring of chronic opioid therapy for the treatment of {opioid dx:17837}. The patient has been taking opioids since \*\*\*.

Previous consultations and workup: \*\*\*

#### MEDICAL HISTORY:

Previous opioids prescribed for pain: {OPIOID MEDS:18781}

Previous history related to opioids: \*\*\*

Current opioid prescriptions: @OPIOIDACTMED@

Current medication side effects: {OPIOID SIDE EFFECTS 2:18778}

Current benzodiazepine prescription/use: \*\*\*

Current skeletal muscle relaxant usage: \*\*\*

Current non-opioid medicines for pain: \*\*\*

WA State PMP reviewed: {Y/N:19851}

Illicit medication history: \*\*\*

Illicit medications that patient expects to show in UDS: \*\*\*

Standardized questionnaire results:

PEG score:

@PEGSCORE@

PHQ-9 score: \*\*\*

AUDIT-C score: \*\*\*

ORT score: \*\*\*

Drug use:

- In the last 12 months, has patient used marijuana? {;19433}  No  Yes \*\*\*
- In the last 12 months, has patient used recreational drugs or prescription medication for non-medical reasons? {;19433}  No  Yes \*\*\*

#### Objective

@PMH@

Medical screening for issues that affect opioid risk:

- OSA? {Y/N:19851}

- Pregnancy risk? {Y/N:19851}

- Pulmonary disease? {Y/N:19851}

- Cardiac disease? {Y/N:19851}

- Renal disease? {Y/N:19851}

- Liver disease? {Y/N:19851}

- Frail or elderly? {Y/N:19851}

@PSH@

@CMEDNM@

Allergies:

@ALLERGY@

@SOCHX@

@FAMHX@

OBJECTIVE:

@VS@

#### Assessment & Plan

Patient assessed to be at {;21416} risk (based on higher of dose category or other evaluation)

Urine Drug Screen ordered today: {Y/N:19851}

Written opioid care plan established: {Y/N:19851}

Problem List diagnosis (GHC.17) entered: {Y/N:19851}

**.opioidproblast 372060**

Opioid Care Plan updated: \*\*\*  
Responsible clinician: @ME@

Chronic opioid medication is used to treat: \*\*\*  
Opioid medications covered under COT plan: \*\*\*  
Pharmacy: \*\*\*

Daily MED: \*\*\*

Intensity monitoring: {:17881} HIGH  
MODERATE  
LOW

Based on: {:22409}

- Lack of 30% improvement in both pain AND function after starting opioids
  - Lung problems (including obstructive sleep apnea and asthma), osteoporosis, falls, liver, kidney problems, age>65
  - History of addiction in patient or household member
  - Use of sleeping pills, alcohol, psychoactive drugs, benzodiazepines
  - Any mental health problems
  - Lack of participation in non-opioid therapies such as exercise, PT, cognitive behavioral therapy, or mindfulness
  - Methadone or fentanyl use
  - Aberrant behaviors (early refill requests, lost meds, intoxication, sedating meds from multiple providers, etc.)
  - Other: \*\*\*
- None

Frequency of monitoring/UDS:  
{OPIOID MONITORING REQS:18786}

High intensity: Office visit with prescribing clinician at least every 3 months; urine drug screen at least once every 12 m  
Moderate intensity: Office visit with prescribing clinician at least every 6 months; urine drug screen at least once every  
Low intensity: Office visit with prescribing clinician at least every 12 months and you may be asked to complete a urine

WA State PMP checked: \*\*\*  
Other information: \*\*\*

**.opioidmini – NEW 420360**

@M@ @LNAME@ is taking \*\*\* pills of \*\*\* per day because of \*\*\*.

PEG score:  
@PEGSCORE@

Factors that increase risk from opioids:  
{:22409}

- Lack of 30% improvement in both pain AND function after starting opioids
  - Lung problems (including obstructive sleep apnea and asthma), osteoporosis, falls, liver, kidney problems, age>65
  - History of addiction in patient or household member
  - Use of sleeping pills, alcohol, psychoactive drugs, benzodiazepines
  - Any mental health problems
  - Lack of participation in non-opioid therapies such as exercise, PT, cognitive behavioral therapy, or mindfulness
  - Methadone or fentanyl use
  - Aberrant behaviors (early refill requests, lost meds, intoxication, sedating meds from multiple providers, etc.)
  - Other: \*\*\*
- None

Patient assessed to be at {LOWMEDHIGH:21416} risk  
Naloxone offered to patients who are medium or high risk: {:19851}  
Written opioid care plan in place: {Y/N:19851}  
Washington State PMP reviewed: {Y/N:19851}  
Urine Drug Screen ordered today: {Y/N:19851}  
Patient's expectation for UDS results: \*\*\*

{Note to clinician: Include diagnosis code "Z79.891 Long-term (current) use of opioid analgesic" and condition being treated.}

Dear @FNAME@,

Thanks for coming in today. I appreciate the opportunity to work with you in developing your care plan. Working together I am optimistic that we can improve your function and sense of well-being.

**GOALS:**

- Maximize your health and quality of life
- Increase your level of function and activity
- Decrease the effect of pain on your life
- Minimize the risk of side effects and ensure the safe use of opioids
- Personal goals: \*\*\*

**WAYS TO HELP YOU MEET YOUR GOALS:**

- Physical activity and participating in meaningful life activities are the most effective ways to improving your sense of well-being.
- A unique benefit here is the Living Well with Chronic Conditions workshops. For more information, call the Resource Line at toll-free 1-800-992-2279 or visit [ghc.org](http://ghc.org) (look under Classes and Events).
- Additional management options: \*\*\*

**MEDICATION PLAN:**

Responsible clinician: @ME@

**@OPIOIDACTMED@**

Opioids are unlikely to relieve all of your pain. While these medicines are known to be effective for a few days, it's unusual for them to provide significant relief for people suffering from long-term painful health conditions.

For some people, these medicines are addictive and have serious side effects. Opioids can cause physical dependence that makes it difficult to stop using them if the dose is increased over time.

**It's important for you to know the risks and side effects in taking opioid medicine.**

**Serious side effects:**

- Slowed breathing that can cause death. This is more likely if you have sleep apnea or chronic lung disease and/or you are on higher opioid doses; if you take more medicine than you're supposed to; or if you mix opioids with alcohol, other prescription medicines (such as sleep aids, muscle relaxers, or tranquilizers), or street drugs.
- Physical dependence, tolerance, or addiction to opioids. Physical dependence means you will experience withdrawal if you stop suddenly. Tolerance means you need to take more of the medicine to get the same effect. Addiction means you are not able to control your use of opioids even if you want to, which might result in harmful outcomes.
- Sedation (sleepiness and sluggishness). This can cloud your judgment and slow your reaction time. Because of this you are at increased risk for falls and accidents while driving, using tools, or operating heavy equipment. Driving while on opioids may be considered driving under the influence (DUI).
- Babies born to mothers taking opioids will be dependent on opioids at birth. You should not take opioids if you are trying to get pregnant. If you do get pregnant while taking opioids, talk with your doctor to make a plan regarding your medicine.

**Common side effects include:**

- Constipation
- Depression
- Itching (this is a side effect and not an allergic reaction)
- Nausea or vomiting
- Decreased sex drive (decreased testosterone)
- Insomnia
- Increased sensitivity to pain (hyperalgesia)

**OPIOID REFILL PROCESS**

- I, @ME@, am the doctor responsible for ordering refills for your medicine. Prescriptions for chronic pain medicine should be provided only by me.
- Your refills will be provided on a schedule with a specific number of pills to last until the next refill.
- Please contact Pharmacy Services 7 days before your scheduled pickup date to refill through your pharmacy.
- For occasional changes in your scheduled refill plan, please contact your care team.
- To guard against theft and accidental ingestion, please take special care with opioids at all times. **Lost or stolen medicine will not be replaced.**

- Many of these medicines contain acetaminophen (Tylenol). Do not take additional medicines that contain acetaminophen (Tylenol). Do not take a total daily dose of more than 3,000mg of acetaminophen without first talking with a member of your care team.

#### REASONS FOR LOWERING DOSE OR STOPPING MEDICINE

I may decide that it is no longer safe or appropriate to continue prescribing chronic opioid therapy, or that I need to taper down the dose of the medicine if:

- You are experiencing side effects from treatment
- You abuse alcohol
- You sell, give away, trade, or share your medicine
- You frequently request refills for lost prescriptions
- Your urine drug screen shows cocaine or methamphetamine, or other “street drugs”
- Your urine shows evidence of medicines that I did not prescribe
- You seek prescriptions for opioid pain medicine from other providers
- New knowledge about opioid therapy becomes available

#### LAB TEST PLAN

- To ensure patient safety, we ask patients to have drug screens on a regular basis. This test will help us make sure you are safe while taking these medicines to manage your pain.
- The results of your urine drug screen (UDS) improve our ability to safely and appropriately manage your opioid treatment plan. Your results will also help us know if you’re taking other medicines that might interfere or cause problems with your opioid treatment.
- As with other tests and exams, the results of your UDS will be part of your medical record.

Depending on your medical coverage, there may be a cost associated with the UDS. For questions about your medical coverage, please call Customer Service at 1-800-901-4636.

If you have any questions about your opioids or urine drug screening, please talk with me at your next appointment or send me a secure message through your MyGroupHealth account on ghc.org. If you don’t have access to your personal online services on MyGroupHealth for Members, I encourage you to do so. Go to ghc.org and click on MyGroupHealth LOG IN, then click Register for MyGroupHealth now.

#### FOLLOW-UP PLAN

Because of the risks associated with taking opioids, we want you to receive regular follow-up while taking these medicines.

Your follow-up plan is:

{OPIOID MONITORING REQS:18786}

- Do not increase the amount of your opioids without first talking with me or another member of your care team.
- During office hours, contact your care team if you have questions or concerns.
- For emergency situations after-hours and on weekends, call the Consulting Nurse Service at 1-800-297-6877 or go to Urgent Care.
- If you require treatment for a new or acute problem from a doctor or clinic other than me or another Kaiser Permanente doctor, I expect that you will tell the other doctor or clinic about the medicines I am already prescribing for you and that we have this established care plan. I also expect that you will let me know if another doctor gives you opioid pain medicine.

#### Learning more about treatments for chronic pain

I’d like you to watch a video about living with chronic pain. This aid includes treatment options with the risks and benefits of each option. To view the video, go to <https://ghc.org/decisions>. Click on **Living Better with Chronic Pain** to start the video. You will be prompted to log in. If you don’t have access to our enhanced online services, follow the instructions to upgrade your account.

#### In case of an overdose:

**Read the following information for using naloxone. Share these instructions with family and friends who might need to help you in case of an overdose.**

Naloxone is used to temporarily reverse the possible life-threatening effects of overdosing on opioids. If you suspect an opioid overdose, it is safe to give naloxone. Naloxone helps the person wake up and keeps them breathing. The person will go into withdrawal, which is unpleasant but not life-threatening.

#### How can I prepare myself to help someone who is having an overdose?

1. Know the signs of an opioid overdose:
  - No response when you yell person’s name or rub the middle of the chest hard
  - Blue lips or fingertips
  - Slow breathing (less than 1 breath every 5 seconds) or no breathing
  - Clammy, cool skin

- Choking sounds or a gurgling, snoring noise
2. Read the patient information included in the prescription.

**What should I do if I think someone is having an overdose?**

1. Lay the person on his or her back to receive a dose of naloxone nasal spray.
2. Remove naloxone nasal spray from the box and open the package.
3. Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
4. Tilt the person's head back, providing support under the neck with your hand.
5. Gently insert the tip of the nozzle into one nostril until your fingers on either side of the nozzle are against the bottom of the person's nose.
6. Press the plunger firmly to give the dose of naloxone nasal spray.
7. Remove the naloxone nasal spray from the nostril after giving the dose.
8. Call 911. Give the address and say your family member or friend is not breathing.
9. If the person is not breathing, try rescue breathing:
  - Make sure nothing is in the person's mouth.
  - Tilt the person's head back, lift the chin, and pinch the nose shut.
  - Give 1 slow breath every 5 seconds until the person starts breathing.
10. If there is no or hardly any breathing, or the person is unresponsive after 2 to 3 minutes, give another dose of naloxone nasal spray in the other nostril.
11. If the person is breathing, put the person on his or her side to prevent choking.
12. Comfort the person until the ambulance arrives.

Dear @FNAME@,

Your safety is our first priority.

The \*\*\* medicine is being tapered for the following reason: \*\*\* - this increases your risk of overdose and other complications from opioid therapy (listed below), and is unsafe.

As we discussed, your \*\*\* prescription will taper off as follows:

**TAPER SCHEDULE FOR \*\*\***

**Take medicine exactly as prescribed. Do not take additional opioid medicines.**

**Prescribed: \*\*\* tablets for \*\*\*-day taper**

**WEEK 1: \*\*\***

**WEEK 2: \*\*\***

**WEEK 3: \*\*\***

**WEEK 4: \*\*\***

**STOP taking medicine.**

While you taper your opioid medicine, you may also use Extra Strength Tylenol (acetaminophen 500 mg tabs). Take 2 tablets up to three times daily as needed. **Do not exceed 3000mg/day total of acetaminophen - this includes prescribed opioids and over-the-counter products.**

While opioids can help some people with bad short-term pain, such as after surgery, they are usually not helpful for managing long-term pain. For some people, these medicines are addictive and have serious side effects. Opioids also cause physical and psychological dependence that makes it difficult to stop using them. Opioid medicines are not indicated for the treatment of low back pain.

**Risks of opioids**

The following table lists serious side effects and how often they happen in 100 people taking opioids.

<b>Serious risks and side effects</b>	<b>In a group of 100 people, how many would experience this side effect?</b>
Opioid overdose	Less than 1, but increases with dosage
Addiction or misuse of opioids	5-30
Depression or anxiety is common among patients using opioids. Pain can worsen depression, just as depression can worsen pain. Opioids can cause loss of interest in usual activities, increasing depression.	unknown
Constipation – can lead to a potentially serious intestinal blockage in less than 1% of patients	30-40
Hormonal effects, including: <ul style="list-style-type: none"> <li>• Lower sex drive (decreased testosterone)</li> <li>• Erection problems (impotence)</li> <li>• Infertility</li> <li>• Osteoporosis (can weaken bones, increasing risk for fracture)</li> </ul>	25-75
Sedation (feeling sleepy or sluggish) - can cause difficulty driving or thinking clearly	15
Problems with sleep and breathing problems during sleep	unknown

**Other common less serious side effects include:**

- Being more sensitive to pain (known as *hyperalgesia*) - more likely if opioid is taken for many years or at high doses
- Muscle twitching
- Itching (this is a side effect and not an allergic reaction)
- Nausea or vomiting
- Dry mouth (may cause tooth decay)

It is possible you have developed opioid dependence as a complication of chronic opioid use and, if so, we can also work with you on treatment options through Behavioral Health Services. To make an appointment, call 206-901-6300 or toll-free 1-888-287-2680.

### **Here are some ways to help you manage chronic pain:**

#### **Exercise**

Physical activity can help reduce pain and improve your physical and mental health. Start gradually with 5 minutes per day for the first week, and increase 1 minute per day each week. Use a stopwatch to measure the gradual increase and to keep from doing too much.

Moderate intensity aerobic training (activities that get your heart pumping) improves overall well-being and physical function. Strength training may help reduce pain and tender points. If it's hard to do activities on your own, physical therapy can help and will include guidance on getting started and staying motivated, pacing yourself, and setting realistic goals.

#### **Cognitive Behavioral Therapy (CBT) – provided by Behavioral Health Services**

CBT may include relaxation, stress management, and pain coping skills.

If you're interested in trying this, please call 206-901-6300 or toll-free 1-888-287-2680 to make an appointment.

#### **Meditation**

Here are some CD tutorials on meditation for people with chronic pain:

*Letting Go Of Stress* by Miller and Halpern

*Mindfulness Meditation for Pain Relief: Guided Practices for Reclaiming Your Body and Your Life* by Jon Kabat-Zinn

#### **Sleep hygiene**

Getting plenty of restful sleep can reduce pain. Practicing good sleep hygiene can help you with sleep. This includes having a regular bedtime, wake-up time, and avoiding naps. Only use your bedroom for sleeping and sexual activity. Don't use your bedroom for working, having discussions, watching TV, or using your computer. Avoid exercise right before going to bed.

#### **Books**

*A Day Without Pain* by Mel Pohl

*Managing Pain Before It Manages You* by Margaret A. Caudill, MD, PhD

*The Pain Chronicles* by Melanie Thernstrom - a history of chronic pain and her own personal story of dealing with chronic pain.

*The Pain Survival Guide: How to Reclaim Your Life* by Dennis C. Turk, PhD

*Feeling Good* by David D. Burns, MD

#### **Living Well Program**

Living Well With Chronic Conditions workshops have helped many people cope with the same challenges you're facing in managing a chronic pain condition. You can participate in one of two ways: attend sessions either in-person at a medical center or online. Visit [ghc.org/livingwell](https://ghc.org/livingwell) for more information and to register for a workshop.

#### **Other medicines**

Other medicines such as Nortriptyline, Venlafaxine, or Gabapentin have also been used as part of a chronic pain management care plan. If you're able to tolerate one of these medicines and we decide to start it, you would take it along with doing other things in your care plan to manage fatigue and pain symptoms, and improve your mental health and well-being.

#### **Learning more about treatments for chronic pain**

I'd like you to watch a video about living with chronic pain. This aid includes treatment options with the risks and benefits of each option. To view the video, go to <https://ghc.org/decisions>. Click on **Living Better with Chronic Pain** to start the video. You will be prompted to log in. If you don't have access to our enhanced online services, follow the instructions to upgrade your MyGroupHealth for Members account.

We look forward to working with you on other ways to help you live better with chronic pain and decrease the effect of pain on your life.

Very kind regards,  
@ME@

**Managing Pain: Important information about opioids**

Today, we talked about creating a care plan to improve your quality of life and ability to stay active. As part of this discussion, we talked about opioid medicines for managing your pain.

Opioids are unlikely to relieve all of your pain. While these medicines are known to be effective for a few days, it's unusual for them to provide significant relief for people suffering from long-term painful health conditions. Research shows that patients taking opioids for long periods of time tend to report having worse pain, and worse mental, physical, and social function than patients with similar health problems not taking opioids.

For some people, these medicines are addictive and have serious side effects. Opioids can cause physical dependence that makes it difficult to stop using them if the dose is increased over time.

**Before I prescribe opioid medicine, it's important for you to know the risks and side effects in taking these drugs.**

The following table lists serious risks and side effects, and how often they happen in 100 people taking opioids.

<b>Serious risks and side effects</b>	<b>In a group of 100 people, how many would experience this side effect?</b>
Opioid overdose	Less than 1, but increases with dosage
Addiction or misuse of opioids	5-30
Depression or anxiety is common among patients using opioids. Pain can worsen depression, just as depression can worsen pain. Opioids can cause loss of interest in usual activities, increasing depression.	unknown
Constipation – can lead to a potentially serious intestinal blockage in less than 1% of patients	30-40
Hormonal effects, including: <ul style="list-style-type: none"><li>• Lower sex drive (decreased testosterone)</li><li>• Erection problems (impotence)</li><li>• Infertility</li><li>• Osteoporosis (can weaken bones, increasing risk for fracture)</li></ul>	25-75
Sedation (feeling sleepy or sluggish) - can cause difficulty driving or thinking clearly	15
Problems with sleep and breathing problems during sleep	unknown

**Other common less serious side effects include:**

- Being more sensitive to pain (known as *hyperalgesia*)
- Muscle twitching
- Itching (this is a side effect and not an allergic reaction)
- Nausea or vomiting
- Dry mouth (may cause tooth decay)

Additionally, babies born to mothers taking opioids will be dependent on opioids at birth. You should not take opioids if you are trying to get pregnant.

**Treatments to help manage your pain with fewer risks**

There are other things we talked about to help manage your pain. These treatments are less risky and can improve your pain for the long-term.

- Over-the-counter medicines, such as acetaminophen (Tylenol), ibuprofen (Advil), or naproxen (Aleve). Follow the package instructions and do not exceed the recommended dose.
- Physical activity and participating in meaningful life activities are the most effective ways to improving your sense of well-being and function.
- Physical therapy, massage therapy and other forms of non-drug treatments might help ease your pain.
- Sign up for a Living Well with Chronic Conditions workshop to learn effective ways to manage your pain. For more information, call the Resource Line at toll-free 1-800-992-2279 or visit [ghc.org](http://ghc.org) (look under Classes and Events).

Additional options we discussed today: \*\*\*

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### **Patient Information: Naloxone nasal spray (Narcan)**

Naloxone is used to temporarily reverse the possible life-threatening effects of overdosing on opioids. If you suspect an opioid overdose, it is safe to give naloxone. Naloxone helps the person wake up and keeps them breathing. The person will go into withdrawal, which is unpleasant but not life-threatening.

#### **How can I prepare myself to help someone who is having an overdose?**

1. Know the signs of an opioid overdose:
  - No response when you yell person's name or rub the middle of the chest hard
  - Blue lips or fingertips
  - Slow breathing (less than 1 breath every 5 seconds) or no breathing
  - Clammy, cool skin
  - Choking sounds or a gurgling, snoring noise
2. Read the patient information included in the prescription.

#### **What should I do if I think someone is having an overdose?**

1. Lay the person on his or her back to receive a dose of naloxone nasal spray.
2. Remove naloxone nasal spray from the box and open the package.
3. Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
4. Tilt the person's head back, providing support under the neck with your hand.
5. Gently insert the tip of the nozzle into one nostril until your fingers on either side of the nozzle are against the bottom of the person's nose.
6. Press the plunger firmly to give the dose of naloxone nasal spray.
7. Remove the naloxone nasal spray from the nostril after giving the dose.
8. Call 911. Give the address and say your family member or friend is not breathing.
9. If the person is not breathing, try rescue breathing:
  - Make sure nothing is in the person's mouth.
  - Tilt the person's head back, lift the chin, and pinch the nose shut.
  - Give 1 slow breath every 5 seconds until the person starts breathing.
10. If there is no or hardly any breathing, or the person is unresponsive after 2 to 3 minutes, give another dose of naloxone nasal spray in the other nostril.
11. If the person is breathing, put the person on his or her side to prevent choking.
12. Comfort the person until the ambulance arrives.

#### **Contact your doctor or Pharmacy if you have questions or concerns.**

Please contact your doctor or Pharmacy Services Monday through Friday between 9 a.m. and 5 p.m. at 1-855-398-9699.