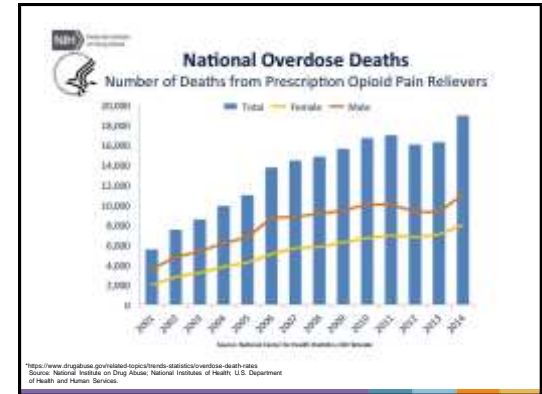


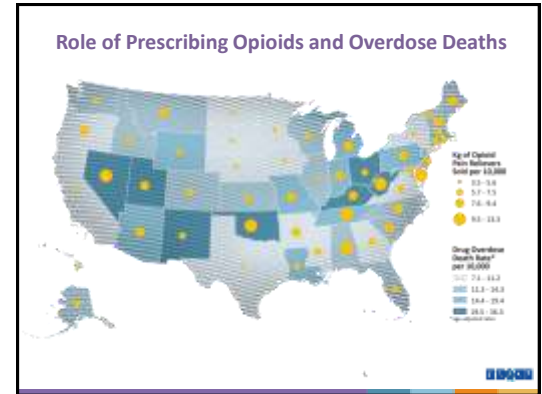
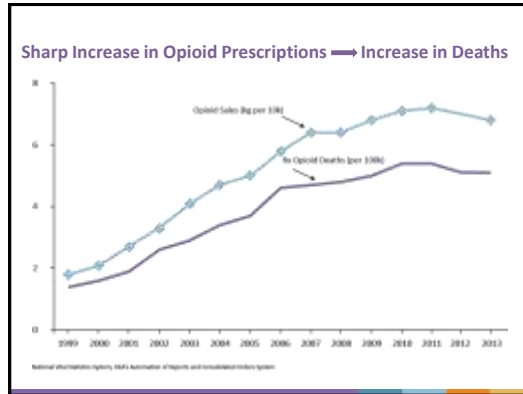
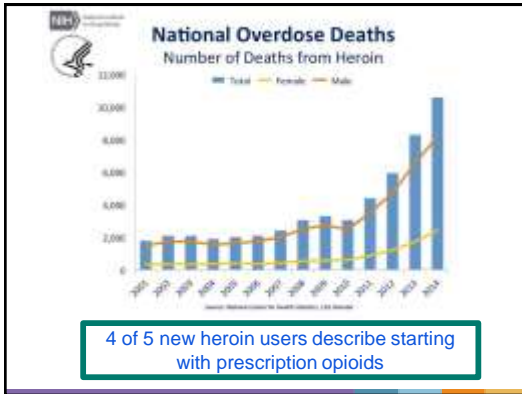
Chronic Pain and Prescription Opioids

- 11% of Americans experience daily (chronic) pain
- Opioids frequently prescribed for chronic pain
- Primary care providers commonly treat chronic, non-cancer pain
 - account for ~50% of opioid pain medications dispensed
 - report concern about opioids and insufficient training

CDC looks at four categories of opioids:

- **Natural opioid analgesics**, including morphine and codeine, and **semi-synthetic opioid analgesics**, including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
- **Methadone**, a synthetic opioid;
- **Synthetic opioid analgesics** other than methadone, including drugs such as tramadol and fentanyl; and
- **Heroin**, an illicit (illegally-made) opioid synthesized from morphine that can be a white or brown powder, or a black sticky substance.

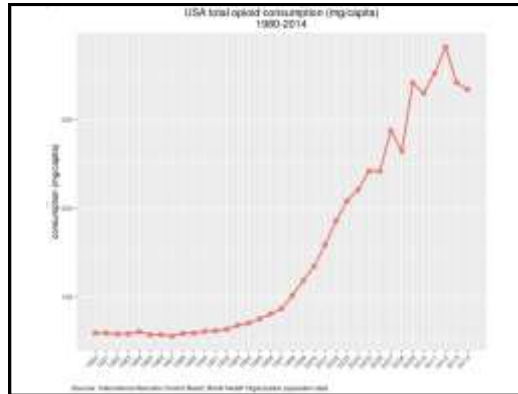




Opioid Prescribing by Morphine Mg Equivalents by County 2015

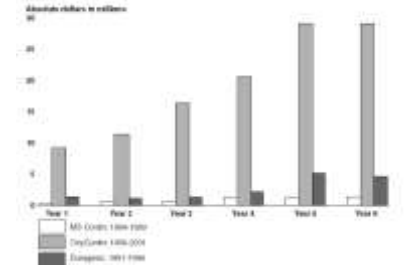


Source: MMWR / July 7, 2017 / Vol. 66 / No. 26 US Department of Health and Human Services/Centers for Disease Control and Prevention



Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales



Source: United States General Accounting Office, Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

"The risk of addiction is much less than 1%"

Porter J, Jick H. *Addiction rare in patients treated with narcotics.* N Engl J Med. 1980 Jan 10;302(2):123

Cited 824 times (Google Scholar)

15

N Engl J Med. 1980 Jan 10;302(2):123.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 38,946 hospitalized medical patients¹ who were monitored consecutively. Although there were 11,863 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,² Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

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HONOR. JACK, M.D.
BOSTON COLLABORATIVE DRUG
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Waltham, MA 02134
BOSTON UNIVERSITY MEDICAL CENTER

1. Jick H, Mittleman GS, Shapiro S, Lewis GP, Stokard Y, Stone D. Comprehensive drug surveillance. JAMA. 1970;213:1483-88.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:186-8.

16

The screenshot shows a website layout with several article titles and logos. At the top, there is a navigation bar with the word "FEATURES" in a dark box. Below it, the main title "Long-term Opioid Treatment of Nonmalignant Pain" is displayed, followed by the author "J. B. Jick, MD, MPH". There are two columns of text. The left column has a sub-header "Issues of Interest: Medication" and a main title "Chronic Noncancer Pain Management and Opioid Overuse: How to Change Prescribing Practices". Below this is the "BMJ" logo. The right column has a sub-header "FEATURES" and a main title "Facing up to the prescription opioid crisis". Below this is the "JAMA" logo. At the bottom, there is a section titled "Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences".

REVIEW **Annals of Internal Medicine**

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD, Judith A. Turner, PhD, Scott B. Dworkin, PhD, MD, MMA, Ryan H. Hansen, PhD, PhD, Scott D. Sullivan, PhD, Imtiaz Ali, MD, Tracy Dawn Bell, Christine Douglas, MPH, and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (≥3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and LINAHE (January 2002 through August 2016); reference articles from a prior review, reference lists, and clinical trials.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy, versus placebo, no opioid, or nonopioid therapy, different opioid dosing strategies, or risk-reduction strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (≥3-year) outcomes related to pain, function, quality of life, overall adverse or withdrawal events, and

low-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for mortality, cognitive decline, respiratory myocardial infarction, and fractures of cervical vertebrae, although there are few studies for each of these outcomes. For some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk-reduction strategies is limited.

Limitations: Non-English language articles, some included meta-analyses could not be done, and publication bias could not be assessed. No placebo-controlled study met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

Conclusions: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a strong recommendation for routine therapy.

Primary Funding Source: Agency for Health Care Research and Quality.

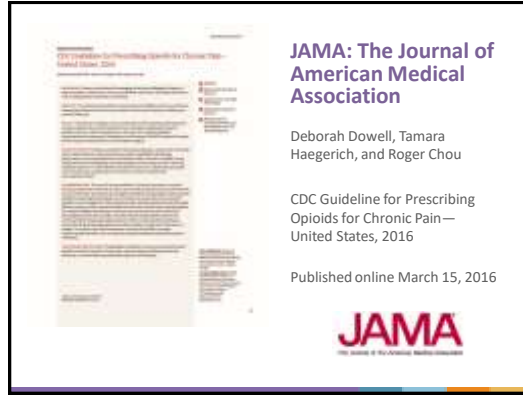
Annotation: PMID 29714113 In Q16. doi:10.7554/AMIA.2017. www.annals.org

the author identifies, but not of that. The article also includes references to a previous systematic review.

Need for Opioid Prescribing Guidelines

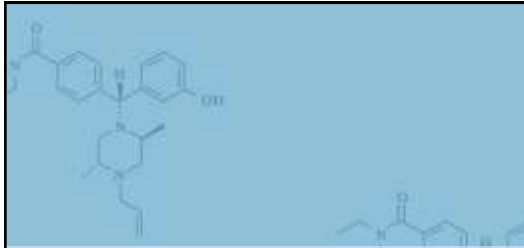
- Previous opioid prescribing guidelines have been developed by several states and agencies but were **inconsistent**
- Most recent national guidelines are **several years old** and don't incorporate the most recent evidence
- Need for **clear, consistent** recommendations

Guideline for Prescribing Opioids for Chronic Pain



Organization of Recommendations

- The 12 recommendations are grouped into three conceptual areas:
 - Determining when to initiate or continue opioids for chronic pain
 - Opioid selection, dosage, duration, follow-up, and discontinuation
 - Assessing risk and addressing harms of opioid use



Determine when to initiate or continue opioids for chronic pain

1

Recommendation #1

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
- Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

(Recommendation category A: Evidence type: 3)

Opioids not first-line or routine therapy for chronic pain

- Use nonpharmacologic therapy such as exercise or cognitive behavioral therapy (CBT) to reduce pain and improve function.
- Use nonopioid pharmacologic therapy (nonsteroidal anti-inflammatory drugs, acetaminophen, anticonvulsants, certain antidepressants) when benefits outweigh risks, combined with nonpharmacologic therapy.
- When opioids used, combine with nonpharmacologic therapy and nonopioid pharmacologic therapy to provide greater benefits.

PEG-Scale Assessing Pain Intensity and Interference (Pain, Equipment, General Activity)

1. What number best describes your **average** pain in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain is 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

Computing the PEG Score:
Add the responses to the three questions, then divide by three to get a mean score (out of 10) on several aspects of pain.

Using the PEG Score:
The score is best used to track an individual's changes over time. The cessation of therapy should result in the individual's score decreasing over time.

Source:
Sexton, J. E., Lussier, R. A., Hais, H. J., Drenth, T. H., Wu, Y., Yankelink, J. M., Arok, S., Kowalski, S. (2008). Development and Initial Validation of the PEG, a Three-Dim Scale of measuring Pain Intensity and Interference. *Journal of General Internal Medicine*, 23(6), 710-718. <https://doi.org/10.1007/s11606-008-0911-1>

3

Recommendation #3

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)

Ensure patients are aware of potential benefits, harms, and alternatives to opioids

- Be explicit and realistic about expected benefits.
- Emphasize goal of improvement in pain and function.
- Discuss
 - serious and common adverse effects
 - increased risks of overdose
 - at higher dosages
 - when opioids are taken with other drugs or alcohol
 - periodic reassessment, PDMP and urine checks; and
 - risks to family members and individuals in the community.



Opioid selection, dosage, duration, follow-up, and discontinuation

4

Recommendation #4

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)

Choose predictable pharmacokinetics and pharmacodynamics to minimize overdose risk

- In general, avoid the use of immediate-release opioids combined with ER/LA opioids.
- Methadone should not be the first choice for an ER/LA opioid.
 - Only providers familiar with methadone’s unique risk and who are prepared to educate and closely monitor their patients should consider prescribing it for pain.
- Only consider prescribing transdermal fentanyl if familiar with the dosing and absorption properties and prepared to educate patients about its use.

5

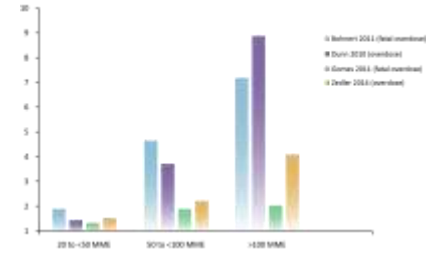
Recommendation #5

- When opioids are started, clinicians should prescribe the lowest effective dosage.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

(Recommendation category A: Evidence type: 3)

Relationship of prescribed opioid dose (MME) and overdose

Odds Ratio or Hazard Ratio for Overdose Relative to 1 to <20 MME



Start low and go slow

- Start with lowest effective dosage and increase by the smallest practical amount.
- If total opioid dosage ≥ 50 MME/day
 - reassess pain, function, and treatment
 - increase frequency of follow-up; and
 - consider offering naloxone.
- Avoid increasing opioid dosages to ≥ 90 MME/day.
- If escalating dosage requirements
 - discuss other pain therapies with the patient
 - consider working with the patient to taper opioids down or off
 - consider consulting a pain specialist.

If patient is already receiving a high dosage

- Offer established patients already taking ≥ 90 MME/day the opportunity to re-evaluate their continued use of high opioid dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.
- For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan.

Equianalgesic Table

ORAL (mg)	Drug	Parenteral (mg)
30	Morphine	10
7.5-8	Hydromorphone	1.5
15-20	Oxycodone	-
200	Codeine	120
300	Demerol	75

Numerous equianalgesic tables published. The best recommendation is to pick one and use it.

Medication	Dose	Interval of Administration	Duration of Administration	First Dosing Interval	Appropriate for PO	Appropriate for IV	First Dosing Interval	Notes
Fentanyl (Duragesic) [®] Patch	25 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	50 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	75 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	100 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	150 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	200 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	250 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	300 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	350 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	400 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	450 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	500 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	550 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	600 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	650 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	700 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	750 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	800 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	850 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	900 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	950 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details
Fentanyl (Duragesic) [®] Patch	1000 mcg	12 hr	1-2 weeks	12-12 hr	Yes	No	12-12 hr	See page 4 for details

<http://mcintranet.musc.edu/aging3/calculationswebsite/convchart.pdf>

Recommendations for Methadone Use

Methadone conversion table: When switching from opioid to methadone, the equivalent dose rates of methadone depend on the OACL, which is reported fully from OACL of the pending opioid.

Opioid (mg/day)	Methadone Dose (mg/day)
10-15	2-3
15-20	3-4
20-30	4-5
30-40	5-6
40-50	6-7
50-60	7-8
60-70	8-9
70-80	9-10
80-90	10-11
90-100	11-12
100-120	12-14
120-150	14-17
150-200	17-22
200-250	22-28
250-300	28-35
300-350	35-43
350-400	43-52
400-450	52-62
450-500	62-73
500-550	73-85
550-600	85-98
600-650	98-112
650-700	112-128
700-750	128-145
750-800	145-165
800-850	165-185
850-900	185-208
900-950	208-232
950-1000	232-258
1000-1100	258-288
1100-1200	288-320
1200-1300	320-355
1300-1400	355-395
1400-1500	395-440
1500-1600	440-490
1600-1700	490-545
1700-1800	545-605
1800-1900	605-670
1900-2000	670-740
2000-2200	740-820
2200-2400	820-915
2400-2600	915-1020
2600-2800	1020-1140
2800-3000	1140-1275
3000-3200	1275-1430
3200-3400	1430-1605
3400-3600	1605-1800
3600-3800	1800-2015
3800-4000	2015-2250
4000-4200	2250-2505
4200-4400	2505-2780
4400-4600	2780-3075
4600-4800	3075-3390
4800-5000	3390-3720
5000-5200	3720-4065
5200-5400	4065-4430
5400-5600	4430-4815
5600-5800	4815-5220
5800-6000	5220-5645
6000-6200	5645-6090
6200-6400	6090-6555
6400-6600	6555-7040
6600-6800	7040-7545
6800-7000	7545-8070
7000-7200	8070-8615
7200-7400	8615-9180
7400-7600	9180-9765
7600-7800	9765-10370
7800-8000	10370-11000
8000-8200	11000-11650
8200-8400	11650-12320
8400-8600	12320-13010
8600-8800	13010-13720
8800-9000	13720-14450
9000-9200	14450-15200
9200-9400	15200-15970
9400-9600	15970-16760
9600-9800	16760-17570
9800-10000	17570-18400

Notes for conversion of opioid to methadone:

- Convert to OACL, calculate equivalent OACL to total dose.
- Divide by 2.5 to obtain.
- Divide by 100 to obtain the methadone dose in mg.
- Divide by 100 to obtain the methadone dose in mg.
- Round down to the nearest whole number.

Example: 100 mg morphine PO q4 PRN

100 mg / 2.5 = 40 mg / 100 = 0.4 mg

Recommended starting dose: 2.5 mg every 12 hours. Do not exceed 10 mg every 12 hours.

NOTE: DURAGESIC is a controlled substance. NOT F. 02121411 with pending or existing methadone will also give management of the way written for conversion and position for methadone, also available on this page.

<http://mcintranet.musc.edu/aging3/calculationswebsite/convchart.pdf>

Fentanyl Patch Guidelines

Current Analgesic	Daily Dosage (mg/day)			
Oral morphine	60-134	135-224	225-314	315-404
Intramuscular or intravenous morphine	10-22	23-37	38-52	53-67
Oral oxycodone	30-67	67.5-112	112.5-157	157.5-202
Oral codeine	150-447			
Oral hydromorphone	8-17	17.1-26	26.1-39	39.1-51
Intravenous hydromorphone	1.5-3.4	3.5-5.6	5.7-7.9	8-10
Intramuscular meperidine	75-165	166-276	279-390	391-503
Oral methadone	20-44	45-74	75-104	105-134
	0	0	0	0
Recommended DURAGESIC Dose	25 mcg/ hour	50 mcg/ hour	75 mcg/ hour	100 mcg/ hour

Fentanyl Patch Guidelines

TABLE 21: RECOMMENDED INITIAL DURAGESIC DOSE BASED UPON DAILY ORAL MORPHINE DOSE

Oral 24-hour Morphine (mg/day)	DURAGESIC Dose (mcg/hour)
60-134	25
135-224	50
225-314	75
315-404	100
405-494	125
495-584	150
585-674	175
675-764	200
765-854	225
855-944	250
945-1034	275
1035-1124	300

6

Recommendation #6

- 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 needed for the expected duration of pain severe enough to require opioids.
- 3 days or less will often be sufficient; more than 7 days will rarely be needed.

(Recommendation category A: Evidence type: 4)

When opioids are needed for acute pain

- Prescribe the lowest effective dose.
- Prescribe amount to match the expected duration of pain severe enough to require opioids.
- Often ≤ 3 days and rarely more than 7 days needed.
- Do not prescribe additional opioids "just in case".
- Re-evaluate patients with severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly.
- Do not prescribe ER/LA opioids for acute pain treatment.

7

Recommendation #7

- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

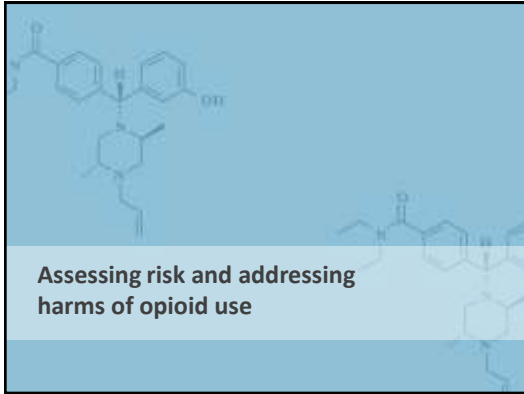
(Recommendation category A; Evidence type: 4)

Follow-up

- Re-evaluate patients
 - within 1-4 weeks of starting long-term therapy or of dosage increase
 - at least every 3 months or more frequently.
- At follow up, determine whether
 - opioids continue to meet treatment goals
 - there are common or serious adverse events or early warning signs
 - benefits of opioids continue to outweigh risks
 - opioid dosage can be reduced or opioids can be discontinued.

Tapering Opioids

- Work with patients to taper opioids down or off when
 - no sustained clinically meaningful improvement in pain and function
 - opioid dosages ≥ 50 MME/day without evidence of benefit
 - concurrent benzodiazepines that can't be tapered off
 - patients request dosage reduction or discontinuation
 - patients experience overdose, other serious adverse events, warning signs.
- Taper slowly enough to minimize opioid withdrawal
 - A decrease of 10% per week is a reasonable starting point
- Access appropriate expertise for tapering during pregnancy
- Optimize nonopioid pain management and psychosocial support



Assessing risk and addressing harms of opioid use

8

Recommendation #8


- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A; Evidence type: 4)

Certain factors increase risks for opioid-associated harms

- Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible.
- During pregnancy, carefully weigh risks and benefits with patients.
- Use additional caution with renal or hepatic insufficiency, aged ≥ 65 years.
- Ensure treatment for depression is optimized.
- Consider offering naloxone when patients
 - have a history of overdose
 - have a history of substance use disorder
 - are taking central nervous system depressants with opioids
 - are on higher dosages of opioids (≥ 50 MME/day).

Overdose Prevention




**Narcan®
(naloxone)**

- Naloxone is a drug used to reverse the effects of opioids.
- Naloxone is safe and effective.
- Naloxone has no effect on non-opioid overdoses.
- In the United States⁹, there are:
 - ✓ Over 180 naloxone programs
 - ✓ Over 50,000 people trained
 - ✓ Over 10,000 overdose reversals (lives saved)

9

Recommendation #9

- Clinicians should review the patient’s history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.
- Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.



(Recommendation category A: Evidence type: 4)

If prescriptions from multiple sources, high dosages, or dangerous combinations

- Discuss safety concerns with patient (and any other prescribers they may have), including increased risk for overdose.
- For patients receiving high total opioid dosages, consider tapering to a safer dosage, consider offering naloxone.
- Consider opioid use disorder and discuss concerns with your patient.
- If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal.
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions.

10

Recommendation #10

- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

(Recommendation category B: Evidence type: 4)

Use UDT to assess for prescribed opioids and other drugs that increase risk

- Be familiar with urine drug testing panels and how to interpret results.
- Don't test for substances that wouldn't affect patient management.
- Before ordering urine drug testing
 - explain to patients that testing is intended to improve their safety
 - explain expected results; and
 - ask patients whether there might be unexpected results.
- Discuss unexpected results with local lab and patients.
- Verify unexpected, unexplained results using specific test.
- Do not dismiss patients from care based on a urine drug test result.

11

Recommendation #11

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

(Recommendation category A: Evidence type: 3)

Avoid concurrent opioids and benzodiazepines whenever possible

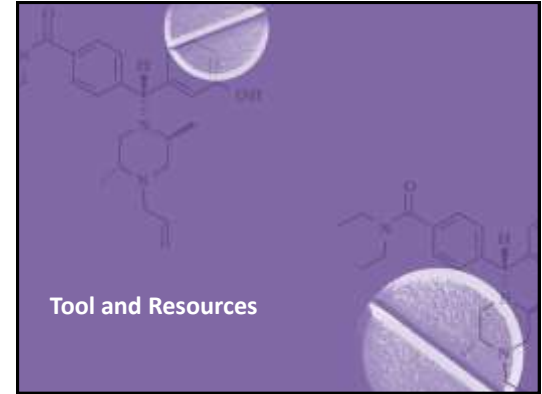
- Taper benzodiazepines gradually.
- Offer evidence-based psychotherapies for anxiety.
 - cognitive behavioral therapy
 - specific anti-depressants approved for anxiety
 - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.

12

Recommendation #12

- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

(Recommendation category A; Evidence type: 2)



Tools and Materials

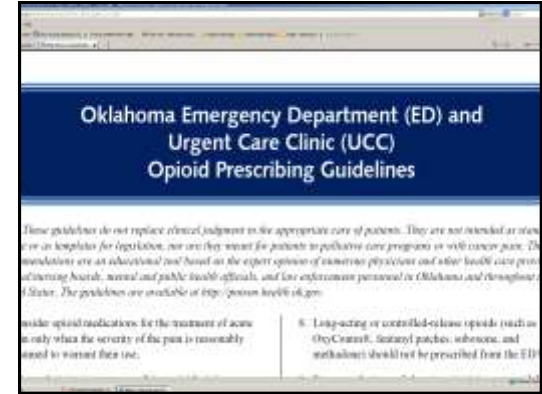


- Provider and patient materials
 - Checklist for prescribing opioids for chronic pain
 - Fact sheets
 - Posters
 - Web banners and badges
 - Social media web buttons and infographics
- CDC Opioid Overdose Website www.cdc.gov/drugoverdose/index.html

Training and Resources



- COCA Call Webinar Series
- Fact sheets
 - New Opioid Prescribing Guideline
 - Assessing Benefits and Harms of Opioid Therapy
 - Prescription Drug Monitoring Programs
 - Calculating Total Daily Dose of Opioids for Safer Prescribing
 - Pregnancy and Opioid Pain Medications



**Opioid Prescribing Guidelines for
Oklahoma Health Care Providers in the Office-Based Setting**

Note: These guidelines do not require clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are educational and based on the expert opinion of numerous physicians and other health care providers, medical licensing boards, medical and public health officials, and law enforcement personnel in Oklahoma and throughout the United States. The guidelines are available at <http://www.health.ok.gov>.

Opioid Treatment for Acute Pain

Opioid Treatment for Chronic Pain

An Act

SENATE BILL NO. 1040

BY: SEN. JEFFREY B. BROWN AND SEN. JEFFREY B. BROWN

and

SEN. ADAM HUGHES OF THE STATE

- 1 hour education in pain management or opioid use/addiction
- 7 day treatment for acute pain
- Under 18 or pregnant must enter into a patient-provider agreement
- May refill for another 7 days with proper documentation
- Third fill must enter into a pain-management agreement

