Opioid Prescribing and Pain Management Policy

Document Number: POL-2024-008 **Effective Date:** January 1, 2024 **Last Revised:** January 1, 2024 **Department:** Clinical Quality / Pain Management / Primary Care **Approved By:** Chief Medical Officer, Pharmacy & Therapeutics Committee, Medical Executive Committee **Review Cycle:** Annual **Evidence Base:** CDC Opioid Prescribing Guideline (2022), FDA Opioid Analgesic REMS

I. PURPOSE AND SCOPE

A. Purpose

This policy establishes comprehensive, evidence-based guidelines for safe opioid prescribing and multimodal pain management to optimize patient outcomes while minimizing risks of addiction, overdose, and diversion. The objectives are to:

1. Provide safe, effective pain management using a multimodal approach
2. Minimize inappropriate opioid prescribing and reduce opioid-related harm
3. Ensure compliance with federal and state opioid prescribing regulations
4. Implement risk mitigation strategies (PDMP checks, urine drug testing, naloxone co-prescribing)
5. Identify and support patients with opioid use disorder (OUD)
6. Promote non-opioid and non-pharmacologic pain management alternatives
7. Support provider education on evidence-based pain management

B. Scope

Applies to:

- All physicians, nurse practitioners, physician assistants, and other authorized prescribers
- All patients receiving opioid prescriptions for pain (acute or chronic)
- Primarily addresses **chronic non-cancer pain** in adults
- Also provides guidance for **acute pain** management

Does NOT cover:

- Cancer pain and palliative/end-of-life care (separate guidelines with different considerations, though some principles overlap)
- Opioid use disorder treatment with buprenorphine/methadone (covered under addiction medicine protocols)
- Perioperative pain management (covered by anesthesiology/surgical protocols, though

principles apply)

C. Regulatory Context

Federal:

- Drug Enforcement Administration (DEA) Controlled Substances Act: Opioids are Schedule II-IV controlled substances
- FDA Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS)
- SUPPORT Act (2018): Requirements for prescriber education

State:

- State-specific Prescription Drug Monitoring Program (PDMP) requirements
- State opioid prescribing limits (e.g., some states limit initial acute pain prescriptions to 3-7 days)
- Mandatory prescriber education requirements

Our Commitment: This policy meets or exceeds all federal and state requirements.

II. DEFINITIONS

Opioids: Natural, synthetic, or semi-synthetic chemicals that interact with opioid receptors to produce morphine-like effects. Includes: morphine, oxycodone, hydrocodone, hydromorphone, fentanyl, tramadol, codeine, etc.

Morphine Milligram Equivalents (MME) per day: A standardized metric to compare opioid doses across different formulations (see Appendix A for conversion table). Example: Oxycodone 20 mg/day = 30 MME/day (conversion factor 1.5).

Acute Pain: Pain with recent onset (typically <3 months) and expected to resolve with tissue healing (e.g., post-surgical, injury, dental pain).

Chronic Pain: Pain persisting beyond normal healing time (typically ≥3 months) or associated with chronic conditions (e.g., chronic low back pain, osteoarthritis, neuropathic pain).

Opioid-Naïve: Patient who has not received opioids chronically (i.e., has not been taking opioids regularly for >1 week).

Opioid-Tolerant: Patient who has been receiving chronic opioid therapy (e.g., ≥60 MME/day for ≥1 week or equivalent).

Opioid Use Disorder (OUD): DSM-5 diagnosis characterized by compulsive opioid use despite harm, including craving, loss of control, continued use despite consequences, tolerance, and withdrawal.

Physical Dependence: Physiological adaptation to chronic opioid use, resulting in withdrawal symptoms if opioids are abruptly discontinued. (Note: Physical dependence is NOT the same as addiction/OUD; it occurs in all patients on chronic opioids.)

Pseudoaddiction: Patient behaviors (drug-seeking) driven by uncontrolled pain rather than addiction; behaviors resolve when pain is adequately treated. (Note: This term is controversial and should be applied cautiously; true addiction should not be dismissed as pseudoaddiction without thorough assessment.)

III. GENERAL PRINCIPLES OF PAIN MANAGEMENT

A. Multimodal, Biopsychosocial Approach

Pain is complex: Involves biological (nociception), psychological (emotions, cognition), and social (functional, occupational) factors.

Multimodal Management:

- **Non-pharmacologic therapies first-line:** Physical therapy, exercise, cognitive-behavioral therapy (CBT), mindfulness, acupuncture, chiropractic, heat/cold, weight loss (for obesity-related pain)
- **Non-opioid pharmacotherapy:** Acetaminophen, NSAIDs, topical analgesics, neuropathic pain medications (gabapentin, pregabalin, duloxetine, tricyclic antidepressants)
- **Opioids:** Reserved for pain that has not responded to non-opioid treatments and when benefits outweigh risks

Individualized Treatment Plans:

- Assess each patient's pain severity, functional impact, comorbidities, and risk factors
- Set realistic, patient-centered goals (e.g., pain reduction to tolerable level, improved function, return to work)
- Shared decision-making with patient

B. "Start Low, Go Slow"

When initiating opioids:

- Use the lowest effective dose
- Start with immediate-release (IR) opioids, not extended-release/long-acting (ER/LA)
- Titrate dose gradually based on response and tolerability
- Reassess frequently

C. Avoid or Justify High-Dose Opioids

High doses (≥50 MME/day, especially ≥90 MME/day) substantially increase overdose risk (dose-response relationship).

CDC Recommendation:

- Use caution when increasing to ≥50 MME/day; carefully reassess risks and benefits
- **Avoid or justify dosages ≥90 MME/day** (only continue if clear benefit and no safer alternatives)

D. Functional Goals Over Pain Scores

Focus on improvement in function and quality of life, not just numeric pain scores.

Examples of Functional Goals:

- Able to work (or return to work)
- Able to perform household tasks, self-care
- Improved sleep
- Able to exercise or engage in hobbies

Pain reduction alone without functional improvement suggests opioids are not providing meaningful benefit.

IV. NON-OPIOID AND NON-PHARMACOLOGIC PAIN MANAGEMENT

These should be the FIRST-LINE treatments for most chronic pain conditions.

A. Non-Pharmacologic Therapies

Physical Modalities:

1. **Physical Therapy (PT):** Strengthening, stretching, manual therapy, modalities (TENS, ultrasound). Evidence-based for low back pain, osteoarthritis, neck pain.
2. **Exercise:** Aerobic exercise, yoga, tai chi. Improves pain and function in chronic pain.
3. **Weight Loss:** For obesity-related pain (osteoarthritis of knees/hips, low back pain).
4. **Heat/Cold Therapy:** Acute injuries (ice), muscle pain (heat).

Psychological/Behavioral: 5. **Cognitive-Behavioral Therapy (CBT) for Pain:** Addresses maladaptive thoughts and behaviors related to pain; improves coping. 6. **Mindfulness-Based Stress Reduction (MBSR):** Meditation, body awareness; reduces pain intensity and improves QoL. 7. **Acceptance and Commitment Therapy (ACT):** Helps patients accept pain and focus on valued activities.

Complementary/Integrative: 8. **Acupuncture:** Evidence for chronic low back pain, osteoarthritis, headache. 9. **Chiropractic/Osteopathic Manipulation:** For some musculoskeletal pain. 10. **Massage Therapy:** Symptom relief for some conditions.

Interventional Procedures: 11. **Injections:** Epidural steroid injections (for radiculopathy), intra-articular injections (corticosteroids or hyaluronic acid for osteoarthritis), trigger point injections. 12. **Nerve Blocks, Radiofrequency Ablation:** For facet joint pain, certain neuropathic pain. 13. **Spinal Cord Stimulation:** For refractory neuropathic pain (e.g., failed back surgery syndrome).

Referrals:

- Refer to **Pain Management Specialists** (anesthesiologists, physiatrists) for complex chronic pain or consideration of interventional procedures.
- Refer to **Behavioral Health** for CBT, chronic pain coping skills.
- Refer to **Physical Therapy, Occupational Therapy** for functional restoration.

B. Non-Opioid Pharmacotherapy

First-Line for Most Chronic Pain:

1. Acetaminophen:

- Dose: Up to 3,000-4,000 mg/day (lower max if liver disease or alcohol use)
- Safe, effective for mild-moderate pain (osteoarthritis, low back pain)
- Caution: Hepatotoxicity at high doses

2. Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):

- Examples: Ibuprofen 400-800 mg TID, Naproxen 500 mg BID, Celecoxib 200 mg daily
- Effective for inflammatory pain (arthritis, musculoskeletal pain)
- Cautions/Contraindications:
    - GI bleed risk (use with PPI if high risk: age >65, history of ulcer, anticoagulation)
    - Cardiovascular risk (avoid in CVD if possible, especially at high doses long-term)
    - Renal impairment (avoid if CKD stage 4-5)
- Use lowest effective dose for shortest duration

3. Topical Analgesics:

- **Topical NSAIDs** (diclofenac gel, ketoprofen cream): For localized musculoskeletal pain (knee OA); fewer systemic side effects than oral NSAIDs
- **Lidocaine patches or cream** (5% patch or 4% cream): For localized neuropathic pain (post-herpetic neuralgia)
- **Capsaicin cream:** For OA, neuropathic pain (causes initial burning, then desensitization)

4. Medications for Neuropathic Pain:

Many chronic pain conditions have a neuropathic component (e.g., diabetic neuropathy, post-herpetic neuralgia, fibromyalgia, chronic low back pain with radiculopathy).

- Gabapentin (Neurontin):
    - Start 100-300 mg at bedtime, titrate to 300-600 mg TID (up to 3600 mg/day)
    - Effective for neuropathic pain; side effects: sedation, dizziness, peripheral edema
- Pregabalin (Lyrica):
    - Start 75 mg BID, titrate to 150-300 mg BID (max 600 mg/day)
    - Similar to gabapentin, often better tolerated or more convenient dosing; more expensive
- Duloxetine (Cymbalta):
    - SNRI antidepressant; FDA-approved for diabetic neuropathy, fibromyalgia, chronic musculoskeletal pain
    - Dose: 30-60 mg daily
    - Also treats comorbid depression/anxiety
- Tricyclic Antidepressants (TCAs):
    - Amitriptyline 10-25 mg at bedtime, titrate to 50-150 mg
    - Effective for neuropathic pain; side effects: sedation, dry mouth, constipation, weight gain, orthostatic hypotension
    - Caution in elderly (falls, cognitive effects), avoid in cardiac conduction abnormalities

5. Muscle Relaxants (Short-Term for Acute Muscle Spasm):

- Cyclobenzaprine, methocarbamol, tizanidine
- Use for acute musculoskeletal pain with spasm (e.g., acute low back strain)
- Duration: ≤2 weeks typically (not for chronic use due to sedation and limited efficacy long-term)

Combination Therapy: Often combine non-opioid agents (e.g., acetaminophen + NSAID, or gabapentin + duloxetine for neuropathic pain).

V. OPIOID PRESCRIBING FOR ACUTE PAIN

A. When Opioids May Be Appropriate for Acute Pain

Indications:

- Moderate-to-severe acute pain expected to last a few days (e.g., post-operative pain, dental extraction, fracture, kidney stone, acute injury)
- After non-opioid analgesics (acetaminophen, NSAIDs) tried or considered insufficient

Goal: Provide short-term pain relief during tissue healing, then taper and discontinue.

B. Prescribing Principles for Acute Pain

1. Use Immediate-Release (IR) Opioids Only:

- Do NOT initiate ER/LA opioids for acute pain (intended for chronic use in opioid-tolerant patients)
- Examples: Oxycodone IR, Hydrocodone-acetaminophen (Norco, Vicodin), Tramadol

2. Lowest Effective Dose:

- For opioid-naïve patients, start with low dose (e.g., oxycodone 5 mg, hydrocodone 5 mg every 4-6 hours as needed)
- Avoid combination products with high acetaminophen doses (risk of exceeding max acetaminophen if taking other acetaminophen products)

3. Short Duration (≤3-7 Days Typically):

- **CDC Recommendation:** ≤3 days of opioids is often sufficient for acute pain; >7 days is rarely needed.
- Many states have laws limiting initial opioid prescriptions (e.g., 5-7 day supply for acute pain)
- **Our Policy:** Initial prescription ≤5 days for most acute pain (exceptions may be made for major surgery or severe trauma, but should be justified)

4. Quantity:

- Prescribe the minimum quantity expected to be needed (e.g., 15-20 tablets for a 3-day supply, assuming 1-2 tablets every 6 hours)
- **Avoid "one size fits all":** Tailor to the patient's pain severity and expected course
- **Do NOT provide automatic refills** – Reassess patient if pain persists beyond initial prescription

5. Patient Education:

- Explain that opioids are for short-term use only
- Discuss risks (sedation, constipation, respiratory depression, addiction)
- Advise taking the lowest effective dose and transitioning to non-opioid analgesics (acetaminophen, NSAIDs) as pain improves
- Counsel on safe storage (lock up, away from children/others) and disposal of unused pills (drug take-back programs)

6. Follow-Up:

- If patient requests refill or reports ongoing pain beyond expected healing time, schedule follow-up visit to reassess (do not reflexively refill)
- Consider alternative diagnoses or non-opioid treatments

C. Special Considerations for Acute Pain

Post-Surgical Pain:

- Collaborate with surgery team; use multimodal analgesia (regional blocks, NSAIDs, acetaminophen) to minimize opioid use
- Prescribe opioids for anticipated duration of severe pain (often 3-7 days for most outpatient surgeries)

Dental Pain:

- NSAIDs (ibuprofen) often as effective as opioids for dental pain
- If opioids needed: 3-day supply typically sufficient

Kidney Stones:

- Severe pain; opioids often needed acutely (ED or urgent care)
- Transition to NSAIDs (ketorolac, ibuprofen) as stone passes (NSAIDs very effective for renal colic)

VI. OPIOID PRESCRIBING FOR CHRONIC PAIN

Chronic opioid therapy is appropriate ONLY when:

1. Non-opioid and non-pharmacologic therapies have been tried and are insufficient
2. Benefits (pain relief and functional improvement) outweigh risks
3. Patient is monitored closely for efficacy and safety

A. Before Starting Chronic Opioid Therapy

1. Establish Treatment Goals:

- Discuss realistic expectations: Opioids may reduce pain by 20-30% (rarely eliminate pain)
- **Set specific functional goals** (e.g., "I want to be able to walk around the block," "I want to return to work part-time")
- Document goals in chart

2. Assess Benefits and Risks:

Potential Benefits:

- Pain reduction
- Improved function (if achieved)

Risks:

- **Opioid Use Disorder (addiction):** ~8-12% of patients on chronic opioids develop OUD
- **Overdose:** Risk increases with dose (especially >50 MME/day) and with co-prescribing benzodiazepines or alcohol use
- **Tolerance and hyperalgesia:** Over time, may need higher doses; paradoxically may increase pain sensitivity
- **Side effects:** Constipation (very common, often requires daily laxative), sedation, nausea, hormonal effects (hypogonadism, low testosterone), immunosuppression
- **Falls (especially in elderly)**

- **Motor vehicle accidents** (impaired driving)

3. Screen for Risk Factors for Opioid Misuse:

High-Risk Factors (consider avoiding opioids or using with extreme caution):

- History of substance use disorder (alcohol, drugs, including opioids)
- Current or past opioid use disorder
- Active mental health disorder (untreated depression, anxiety, PTSD)
- History of overdose
- Concurrent benzodiazepine or other sedative use

Moderate-Risk Factors:

- Young age (<65 years; younger patients higher risk for misuse, though elderly higher risk for falls/overdose)
- Tobacco use (associated with higher misuse risk)
- Sleep apnea
- Renal or hepatic impairment (altered drug metabolism)

Use Screening Tools:

- **Opioid Risk Tool (ORT)** or **SOAPP-R (Screener and Opioid Assessment for Patients with Pain–Revised)** – validated questionnaires to assess misuse risk

Document risk assessment.

4. Informed Consent and Treatment Agreement:

Obtain Written Informed Consent covering:

- Diagnosis and treatment plan
- Expected benefits and goals
- Risks of opioid therapy (addiction, overdose, side effects)
- Alternatives to opioids (already tried or available)
- Monitoring plan (clinic visits, urine drug testing, PDMP checks)
- Safe use, storage, and disposal
- Pregnancy risks (opioids in pregnancy can cause neonatal abstinence syndrome)
- Driving impairment (advise caution, check state laws)

Pain Management Agreement (Opioid Contract): Patients on chronic opioids sign an agreement outlining:

- **One Prescriber, One Pharmacy:** Patient agrees to obtain opioids from only this provider and one designated pharmacy (to prevent "doctor shopping")
- No early refills
- Lost or stolen prescriptions will not be replaced (or replaced only once per year with police report)
- Consent to random urine drug tests and PDMP checks
- No sharing, selling, or diversion of medications
- Agreement to follow treatment plan and attend follow-up visits
- Understanding that opioids may be tapered or discontinued if agreement violated or if not effective

Template agreement is in Appendix B.

B. Initiating Chronic Opioid Therapy

1. Start with Immediate-Release (IR) Opioids:

- Do NOT start with ER/LA opioids (long-acting formulations are for opioid-tolerant patients on stable chronic therapy)
- Examples: Oxycodone IR, Hydrocodone-acetaminophen, Morphine IR, Tramadol

2. Lowest Effective Dose:

- Opioid-naïve patients: Start with 10-20 MME/day (e.g., oxycodone 5 mg every 6 hours PRN = 20 MME/day)
- Titrate dose slowly (every 1-2 weeks) based on pain and function

3. Scheduled vs. PRN:

- **PRN (as needed) dosing** often preferred initially to use the minimum effective dose
- **Scheduled dosing** (e.g., every 4-6 hours around the clock) may be used if pain is constant and severe, but increases risk of tolerance and dependence

4. Avoid Combination Opioid-Acetaminophen Products Long-Term:

- Hydrocodone-acetaminophen and oxycodone-acetaminophen limit dosing flexibility (risk of exceeding max acetaminophen 4 g/day if taking multiple tablets)
- If chronic use anticipated, consider single-agent opioid (oxycodone, morphine) so acetaminophen can be dosed separately

C. Follow-Up and Monitoring

Frequent Reassessment:

- **Initial visit (1-4 weeks after starting opioids):** Assess pain reduction, functional improvement, side effects, adherence
- **Every 3 months (at minimum) for stable patients** on chronic opioids
- **More frequently if:**
    - Dose >50 MME/day
    - Concerns about misuse or adverse effects
    - Escalating doses
    - New risk factors (e.g., started on benzodiazepine)

At Each Follow-Up Visit, Assess "The 4 A's":

1. **Analgesia:** Is pain reduced? By how much? (Use 0-10 scale, but emphasize function over numbers)
2. **Activity/Function:** Has the patient's function improved? Meeting goals?
3. **Adverse Effects:** Side effects? Constipation (address with laxatives), sedation, falls, etc.?
4. **Aberrant Behaviors:** Any concerning behaviors suggesting misuse? (Early refills, lost prescriptions, dose escalation, obtaining from multiple providers, etc.)

If benefits do NOT clearly outweigh harms, initiate taper and discontinuation (see Section VI.E).

D. Dose Escalation and High-Dose Opioids

Caution at ≥50 MME/day:

- Reassess risks vs. benefits carefully
- Overdose risk begins to increase significantly

Avoid or Justify ≥90 MME/day:

- **CDC Guideline:** Avoid dosages ≥90 MME/day, or carefully justify decision to continue and document in chart
- **If prescribing ≥90 MME/day:**
    - Discuss risks with patient (risk of overdose >2-fold higher than at 20-50 MME/day, and >10-fold higher than no opioids)
    - Ensure patient on naloxone (see Section VII.D)
    - More frequent follow-up (monthly or every 6 weeks)
    - Consider consultation with pain specialist or addiction medicine

Document Rationale: If continuing high dose, chart note should include:

- Why high dose is necessary (pain and function response)

- What alternatives were considered or tried
- Patient's understanding of risks
- Harm reduction strategies in place

Consider Opioid Rotation: If patient on high dose of one opioid with poor response, consider rotating to a different opioid (may improve analgesia due to incomplete cross-tolerance). Consult pain specialist.

E. Tapering and Discontinuing Opioids

Indications for Taper:

1. **Lack of benefit:** No meaningful pain reduction or functional improvement despite adequate trial (e.g., 3 months)
2. **Harms outweigh benefits:** Significant side effects, concerning aberrant behaviors, overdose event
3. **Patient request:** Patient wishes to discontinue opioids
4. **High-dose opioids without clear benefit**
5. **Development of contraindication** (e.g., severe sleep apnea, OUD)

Tapering Principles:

1. Collaborative, Gradual Taper:

- **Discuss with patient** reasons for taper and involve them in the plan (sudden forced tapers can harm therapeutic relationship and drive patients to seek illicit opioids)
- **Gradual taper:** Reduce dose by 5-10% per month (slower for patients on opioids for years)
- Example: Patient on 60 MME/day → reduce by 5 MME every 2-4 weeks
- Some patients may need much slower tapers (e.g., 10% every 2-3 months) to minimize withdrawal

2. Manage Withdrawal Symptoms:

- Expect mild withdrawal symptoms (anxiety, sweating, myalgias, insomnia, GI upset) even with gradual taper
- Supportive care: Clonidine for autonomic symptoms, ibuprofen for aches, loperamide for diarrhea, sleep aids
- Consider adjunctive medications: Clonidine 0.1 mg BID-TID, or gabapentin

3. Enhance Non-Opioid Therapies:

- Intensify physical therapy, behavioral therapy, non-opioid medications during taper
- Offer referrals to pain management, PT, behavioral health

4. Monitor and Reassess:

- Frequent follow-up during taper (every 2-4 weeks initially)
- Adjust taper speed based on patient tolerance
- If patient develops severe withdrawal or uncontrolled pain, may slow taper further or pause temporarily

5. If Opioid Use Disorder Suspected:

- Consider referral to addiction medicine for medication-assisted treatment (buprenorphine or methadone)
- Do NOT abandon the patient; continue to provide care or ensure transfer to appropriate provider

---

VII. RISK MITIGATION STRATEGIES

A. Prescription Drug Monitoring Program (PDMP) Checks

PDMP (Prescription Monitoring Program): State database tracking all controlled substance prescriptions filled in the state (and often interstate data sharing).

Purpose: Identify patients receiving prescriptions from multiple providers ("doctor shopping") or filling prescriptions at multiple pharmacies, detect potential diversion.

Our Policy:

Mandatory PDMP Checks:

1. **Before prescribing opioids for the first time** to a patient (any opioid prescription)
2. **Before initiating chronic opioid therapy** (re-check even if checked previously)
3. **At least every 3 months** for patients on chronic opioid therapy (more frequently if concerns)
4. **Before any dose increase** (especially if escalating to ≥50 MME or ≥90 MME)
5. **If any red flags arise** (patient requests early refill, reports lost prescriptions, etc.)

How to Access PDMP:

- Log in to [State PDMP Portal] using provider credentials
- Search patient by name and DOB
- Review controlled substance prescriptions in past 12 months

Red Flags in PDMP:

- Multiple prescribers for opioids (overlapping prescriptions)
- High MME/day from combined prescriptions
- Prescriptions for opioids + benzodiazepines (dangerous combination)
- Filling prescriptions at multiple pharmacies
- Frequent early fills

Action if Red Flags Found:

- Discuss findings with patient (non-judgmental; there may be legitimate explanations)
- If concern for misuse, consider urine drug test, intensify monitoring, or initiate taper
- If concern for diversion (obtaining opioids to sell/give away), discontinue opioids and refer to addiction treatment

Documentation:

- Document in chart that PDMP was checked, date, and findings (or "No concerns")

B. Urine Drug Testing (UDT)

Purpose:

- Verify patient is taking prescribed opioid (not diverting)
- Detect use of non-prescribed substances (illicit drugs, non-prescribed opioids or benzodiazepines)
- NOT a "gotcha" test, but a safety and adherence tool

Our Policy:

Urine Drug Test:

1. **Baseline:** Before starting chronic opioid therapy (or at first visit for established patients)
2. **Periodically:** At least annually, or more often (every 3-6 months) for higher-risk patients
3. **Random/Unannounced:** UDT should be presented as routine care (not punitive)

Test Types:

- **Immunoassay (IA) Screen:** Initial screening test (in-office cup or send to lab); detects classes of drugs (opiates, oxycodone, benzodiazepines, THC, cocaine, amphetamines)
- **Confirmatory Testing (GC-MS or LC-MS/MS):** If IA is positive or unexpected, send for confirmatory testing to identify specific drug and confirm presence

Interpretation:

Expected Results:

- Prescribed opioid present (and metabolites)
- No non-prescribed controlled substances

Unexpected Results and Actions:

Finding	Possible Explanation	Action
Prescribed opioid NOT detected	Not taking medication (diversion? stocking pills?)	Discuss with patient; if diversion suspected, discontinue opioids
	Taking much less than prescribed (poor adherence, or saving pills)	Assess barriers to adherence; adjust dose if taking less
Non-prescribed opioid detected	Obtained from another source (doctor shopping, illicit purchase, family member sharing)	Review PDMP; confront discrepancy; may need to taper/discontinue
Illicit drug detected (cocaine, heroin)	Active substance use disorder	Urgent: Assess for OUD, offer referral to addiction treatment; discontinue opioids or transition to buprenorphine if appropriate
Benzodiazepine detected (not prescribed by you)	Prescribed by another provider, or illicit	Review PDMP; dangerous combination with opioids; coordinate care or discontinue opioid if unable to ensure safety
THC (marijuana) detected	Recreational or medical marijuana use (legal in some states)	Discuss risks (cognitive impairment, may interact with opioids); individual decision based on state laws and practice policy

Documentation:

- Document UDT result and interpretation in chart
- If unexpected result, document discussion with patient and plan

Important Notes:

- **Explain UDT policy to patients upfront** (in consent and treatment agreement) so they understand it is routine
- Approach with empathy and non-judgment (patient may have explanations, such as took someone else's medication once in an emergency)
- UDT is a clinical tool, not a punitive measure; goal is safety

C. Avoid Co-Prescribing Benzodiazepines and Other CNS Depressants

Opioids + Benzodiazepines (or other sedatives) = DANGEROUS COMBINATION

Evidence:

- Concurrent use of opioids and benzodiazepines increases overdose death risk by ~4-fold
- Both depress respiration; synergistic effect

Our Policy:

AVOID prescribing benzodiazepines to patients on opioids whenever possible.

If Patient is Already on Both (from previous providers or your own prior prescriptions):

1. **Assess necessity:**
    - Is the benzodiazepine truly needed? Can anxiety or insomnia be managed with non-benzo alternatives (SSRIs, buspirone, trazodone, CBT)?
    - Is the opioid truly needed? Can pain be managed with non-opioids?
2. **Taper one or both:**
    - **Preferred:** Taper and discontinue benzodiazepine (gradually, over weeks to months to avoid withdrawal/seizures)
    - **Alternative:** Taper and discontinue opioid
    - **If both are truly needed and cannot be discontinued:** Use lowest doses of each, educate patient on risks, ensure naloxone is prescribed, more frequent monitoring
3. **Document rationale** if continuing both (e.g., "Patient has severe anxiety and chronic pain; multiple taper attempts unsuccessful; patient aware of overdose risk; naloxone prescribed")

Do NOT initiate benzodiazepines in patients on chronic opioids unless absolutely necessary and after consultation with psychiatry/addiction medicine.

Other CNS Depressants to Avoid or Use Cautiously:

- Muscle relaxants (cyclobenzaprine, carisoprodol)
- Sleep aids (zolpidem, eszopiclone)
- Gabapentin and pregabalin (have some CNS depressant effects, especially at high doses)
- Alcohol (counsel patients to avoid alcohol while on opioids)

D. Naloxone (Narcan) Co-Prescribing

Naloxone: Opioid antagonist that reverses opioid overdose (restores breathing). Available as nasal spray (Narcan) or auto-injector (Evzio) for layperson use.

Our Policy:

Offer and prescribe naloxone to patients with increased overdose risk:

Indications for Naloxone Co-Prescribing:

1. **High-dose opioids** (≥50 MME/day)
2. **Concurrent benzodiazepine or other CNS depressant use**
3. **History of overdose** (any prior opioid overdose)
4. **History of substance use disorder** (especially opioid use disorder)
5. **Other respiratory conditions** (sleep apnea, COPD, asthma)
6. **Anyone else in the household who may have access to the patient's opioids** (children, adolescents, others with substance use)

Also CONSIDER naloxone for ANY patient on chronic opioids (universal offering is becoming standard of care).

Naloxone Formulations:

- **Nasal spray (Narcan 4 mg):** Easiest to use; one spray per nostril
- **Injectable (0.4 mg/mL):** Requires IM or SQ injection

Patient/Family Education on Naloxone:

- **When to use:** If person is unresponsive, not breathing or only gasping, blue/gray lips or skin (suspected overdose)
- **How to use:** Call 911 first, then administer naloxone (nasal spray: insert in nostril, press plunger; or inject IM in thigh/arm), perform rescue breathing or CPR if trained, repeat dose every 2-3 minutes if no response (naloxone can be given multiple times, no harm in giving even if not opioid overdose)
- **Naloxone causes immediate withdrawal** in opioid-dependent persons (patient may wake up uncomfortable, agitated); this is expected and not harmful
- **Patient must still go to hospital** (even if naloxone reverses overdose, effects may wear off and person may re-overdose, especially if long-acting opioid)

Good Samaritan Laws: Most states have laws protecting people who call 911 and administer naloxone from legal liability. Educate patients and families.

Prescribing:

- Naloxone Nasal Spray 4 mg: Dispense 2 devices (in case multiple doses needed)
- Covered by most insurance (some copay); also available over-the-counter in many states

---

VIII. RECOGNIZING AND RESPONDING TO OPIOID USE DISORDER

A. Recognizing OUD

Opioid Use Disorder (OUD) is a medical condition, not a moral failing. It is characterized by compulsive opioid use despite harm.

DSM-5 Criteria (≥2 in 12 months indicates OUD):

1. Opioids taken in larger amounts or over a longer period than intended
2. Persistent desire or unsuccessful efforts to cut down or control use
3. Great deal of time spent obtaining, using, or recovering from opioids
4. Craving or strong desire to use opioids
5. Recurrent use resulting in failure to fulfill major obligations (work, school, home)
6. Continued use despite social or interpersonal problems caused by opioids
7. Important activities given up because of opioid use
8. Recurrent use in situations where physically hazardous
9. Continued use despite knowing it is causing or worsening physical or psychological problems
10. Tolerance (need for increased amounts or diminished effect)
11. Withdrawal (or taking opioids to avoid withdrawal)

Clinical Signs/Behaviors Suggesting OUD:

- Escalating dose requests without improved function
- Frequent early refill requests, lost prescriptions
- Obtaining opioids from multiple providers (PDMP findings)
- Borrowing or stealing others' opioids
- Forging prescriptions
- Diversion (selling or giving away opioids)
- Continued use despite adverse consequences (job loss, family conflict, legal issues)
- Using opioids in ways other than prescribed (crushing and snorting, injecting)
- UDT showing no prescribed opioid present (diversion) or illicit drugs present

Important Distinction:

- **Physical dependence and tolerance** are expected with chronic opioid use and are NOT the same as OUD
- **Pseudoaddiction** (drug-seeking due to uncontrolled pain) can look like OUD, but behaviors resolve when pain is adequately treated; be cautious not to label true addiction as pseudoaddiction

B. Approach to Patient with Suspected OUD

1. Non-Judgmental Discussion:

- Express concern for patient's health
- "I've noticed [behavior], and I'm concerned you may be struggling with opioid use. Let's talk about how we can help you."

2. Assessment:

- Obtain history: How much opioid is patient actually taking? Using from other sources?
- Screen for other substance use (alcohol, benzodiazepines, illicit drugs)
- Assess readiness to change (motivational interviewing techniques)

3. Treatment Options:

Medication-Assisted Treatment (MAT) for OUD:

MAT is the gold standard for OUD treatment (combining medication + counseling).

Medications:

- Buprenorphine (Suboxone, Subutex):
  - Partial opioid agonist; reduces cravings and withdrawal without producing euphoria (at therapeutic doses)
  - Can be prescribed in office-based setting by providers with DEA-X waiver (or per recent changes, any DEA-licensed prescriber can prescribe for up to 30 patients without waiver)
  - **Our practice:** [If we have waivered prescribers] We can initiate buprenorphine here. [If not] We refer to addiction medicine or MAT clinic.

- Methadone:
  - Full opioid agonist; dispensed daily at methadone clinic (federally regulated)
  - Effective for moderate-severe OUD
  - Referral to methadone clinic required

- Naltrexone (Vivitrol):

- Opioid antagonist (blocks opioid effects); monthly injectable
- Used after detox (patient must be opioid-free for 7-10 days before starting)
- Less commonly used than buprenorphine or methadone, but option for motivated patients

Counseling/Behavioral Therapy:

- Cognitive-behavioral therapy, contingency management, support groups (Narcotics Anonymous)

4. Referral:

- Refer to **Addiction Medicine Specialist, Addiction Psychiatrist, or MAT Clinic**
- Provide patient with resources: SAMHSA Treatment Locator (1-800-662-HELP, findtreatment.gov)

5. Continue to Provide Care:

- **Do NOT abandon the patient** (even if you discontinue opioid prescriptions)
- Offer non-opioid pain management, support, and facilitate MAT referral
- Overdose risk is high during transitions; ensure naloxone is provided

C. If Patient Refuses Treatment for OUD

If patient has OUD but refuses treatment:

- Discontinue opioid prescriptions (continuing to prescribe opioids in the setting of OUD is unethical and may be illegal)
- Continue to offer support and referrals
- Provide naloxone
- Maintain therapeutic relationship; patient may be ready for treatment in the future

If unable to safely discontinue opioids immediately (e.g., patient on very high dose, risk of severe withdrawal, risk patient will seek illicit opioids):

- Collaborate with addiction medicine or pain specialist for managed taper or bridge to MAT

IX. SPECIAL POPULATIONS

A. Pregnancy

Opioids in Pregnancy:

- Opioids cross the placenta; chronic use can cause **Neonatal Abstinence Syndrome (NAS)** (newborn withdrawal after birth)
- **However:** Untreated severe pain in pregnancy is also harmful (maternal and fetal stress)

Management:

- **Avoid opioids if possible** in pregnant women; use non-opioid analgesics (acetaminophen is safe; NSAIDs generally avoided in 3rd trimester)
- **If opioids needed:** Use lowest dose and shortest duration; immediate-release formulations
- **If patient with OUD becomes pregnant:** Do NOT taper or discontinue opioids abruptly (high risk of relapse, overdose, fetal distress); transition to **buprenorphine or methadone** (MAT for OUD in pregnancy is standard of care and safer than continued illicit opioid use)
- **Coordinate with obstetrics** and neonatology (baby will need monitoring for NAS after delivery)

B. Older Adults (≥65 Years)

Special Considerations:

- Older adults are at higher risk for opioid-related adverse effects (falls, fractures, cognitive impairment, respiratory depression)
- Age-related changes in metabolism (reduced renal/hepatic clearance)
- Often on multiple medications (polypharmacy, drug interactions)

Management:

- **Start low, go slow** (use lower starting doses, e.g., 50% of typical adult dose)
- **Avoid long-acting opioids** (higher risk of accumulation and overdose)
- **Avoid high-dose opioids** (>50 MME/day in elderly is high risk)
- **Screen for fall risk, cognitive impairment, sleep apnea**
- **Use non-opioid therapies aggressively** (PT, topical analgesics, etc.)

C. Patients with Renal or Hepatic Impairment

Opioid metabolism is affected by kidney and liver function.

Renal Impairment:

- Morphine and codeine have active metabolites that accumulate in renal failure (increased risk of toxicity)

- **Preferred opioids in CKD:** Oxycodone, hydromorphone (in reduced doses), fentanyl (no active metabolites)
- Avoid tramadol in severe renal impairment (increased seizure risk)

Hepatic Impairment:

- Reduced metabolism; start with lower doses and longer intervals
- Avoid tramadol and codeine (require hepatic activation)

D. Patients with Sleep Apnea

Opioids worsen sleep apnea (depress respiratory drive during sleep).

Management:

- **Avoid opioids if possible** in patients with moderate-severe obstructive sleep apnea (OSA)
- If opioids necessary: Use lowest dose, ensure patient on CPAP therapy, consider sleep study if OSA not previously diagnosed
- Prescribe naloxone

X. DOCUMENTATION REQUIREMENTS

Every opioid prescription (especially for chronic therapy) must be accompanied by thorough documentation.

Required Elements in Chart Note:

1. **Pain Assessment:**
    - Location, quality, severity (0-10 scale), duration
    - Impact on function (work, sleep, daily activities)
2. **Physical Exam:**
    - Pertinent findings (e.g., tenderness, range of motion, neurologic exam if applicable)
3. **Diagnosis/Diagnoses:** ICD-10 code(s)
4. **Treatment Plan:**
    - Opioid prescribed (name, dose, quantity, duration)
    - Rationale for opioid therapy (why opioids are necessary)
    - Goals of therapy (functional goals)

- Non-opioid treatments tried or recommended

5. **Risk Assessment:**

- PDMP checked (date, findings)
- UDT results (if obtained)
- Risk factors for misuse/overdose

6. **Informed Consent/Treatment Agreement:**

- Note that risks/benefits discussed and treatment agreement signed (reference date)

7. **Monitoring Plan:**

- Follow-up interval
- Plan for reassessment

8. **If High-Dose (≥90 MME/day) or Other Deviations from Guideline:**

- Document justification (why benefits outweigh risks)

Use structured templates or EHR pain management flowsheets to facilitate documentation.

XI. PROVIDER EDUCATION AND COMPETENCY

A. Mandatory Training

All prescribers must complete:

- **Initial pain management and opioid prescribing training** (3-hour online module or in-person course) within 6 months of hire
- **Annual refresher training** (1 hour) on updates to guidelines, state laws, and best practices

Content:

- Evidence-based pain management
- CDC Opioid Prescribing Guideline
- Recognizing and managing OUD
- Use of PDMP and UDT
- Naloxone prescribing

B. Peer Review

Quarterly peer review of high-dose opioid prescribing:

- Medical Director or Pain Management Committee reviews list of patients on ≥90 MME/day
- Chart review to ensure appropriate documentation and adherence to policy
- Feedback to prescribers; offer support and education if needed

---

XII. COMPLIANCE AND ENFORCEMENT

A. Monitoring

Pharmacy & Therapeutics Committee and Pain Management Committee:

- Monitor opioid prescribing patterns (total MME prescribed, % of patients >90 MME, prescription durations)
- Identify outlier prescribers for education or review

State and Federal Audits:

- DEA and state boards may audit prescribing practices
- Non-compliance can result in sanctions, loss of DEA license, or legal action

B. Non-Compliance with Policy

Prescribers who do not follow this policy may be subject to:

- Counseling and re-education
- Prescribing restrictions (e.g., must consult pain specialist for high-dose opioids)
- Referral to Medical Executive Committee for review
- Disciplinary action up to termination or loss of privileges

Patient non-compliance with treatment agreement:

- May result in taper and discontinuation of opioids (with adequate support and referral)

XIII. REFERENCES

1. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep.* 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1
2. Chou R, Turner JA, Devine EB, et al. 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. *Ann Intern Med.* 2015;162(4):276-286.
3. U.S. Food and Drug Administration. Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS). https://www.fda.gov/drugs/information-drug-class/opioid-analgesic-risk-evaluation-and-mitigation-strategy-rems
4. American Society of Addiction Medicine. National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med.* 2020;14(2S Suppl 1):1-91.
5. Substance Abuse and Mental Health Services Administration (SAMHSA). Medication-Assisted Treatment (MAT). https://www.samhsa.gov/medication-assisted-treatment

---

XIV. APPENDICES

Appendix A: Morphine Milligram Equivalent (MME) Conversion Table

Opioid	Conversion Factor (to MME)	Example
Codeine	0.15	30 mg codeine = 4.5 MME
Hydrocodone	1	10 mg hydrocodone = 10 MME
Oxycodone	1.5	20 mg oxycodone = 30 MME
Morphine	1	30 mg morphine = 30 MME
Hydromorphone	4	4 mg hydromorphone = 16 MME
Fentanyl transdermal (mcg/hr)	2.4	25 mcg/hr patch = 60 MME/day
Methadone (complicated, see table)	Variable	20 mg methadone = ~80-120 MME (depending on dose)
Tramadol	0.1	50 mg tramadol = 5 MME

Example Calculation: Patient on oxycodone 10 mg TID (3 times/day): 10 mg x 3 = 30 mg/day oxycodone. 30 mg x 1.5 = **45 MME/day**.

Appendix B: Pain Management Agreement / Opioid Treatment Agreement (Template)

Appendix C: Opioid Risk Tool (ORT) Screening Questionnaire

Appendix D: Naloxone (Narcan) Patient Education Handout

Appendix E: Opioid Taper Plan Template

END OF POLICY

For questions, contact:

- Pain Management Specialist: (555) 300-1000
- Addiction Medicine Clinic: (555) 300-2000
- Pharmacy (medication questions): (555) 300-3000
- Compliance/Policy Questions: Chief Medical Officer (555) 300-4000

Document Control:

- Version: 1.0
- Effective: January 1, 2024
- Next Review: January 1, 2025