



MONITORING PRACTICES TO PROMOTE SAFER OPIOID USE

S HARE A PATIENT PROVIDER AGREEMENT (PPA) with clearly established boundaries and patient expectations PRIOR to initiating a trial of opioids for chronic non-cancer pain

- A PPA signed by both patient and provider and given to the patient is an important, convenient tool that can also **document patient counseling and education**.
- **Offering a PPA to all patients** regardless of a patient's identified risk of opioid misuse and abuse **reduces stigma** and provides a minimal level of precaution/protection to prescriber and patient.
- There is no standard, validated, or legally binding form of a PPA; **consider inclusion of informed consent** (e.g., potential risks and benefits of an opioid trial, continuation, and discontinuation) **and plan of care** (e.g., goals of care, expectations, rights and responsibilities of provider and patient).

O PTIMIZE PATIENT TREATMENT (DRUG/NON-DRUG) USING A MULTI-DIMENSIONAL RATING SCALE to assess chronic pain, quality of life, and progress toward functional goals

- The **PEG** is a brief multi-functional measure of **Pain**, **Enjoyment of life**, and **General activity** **useful at baseline and at regular intervals** to assess and document patient response to treatment.
- **Set realistic expectations** that full pain relief is unlikely **and set individualized goals** that are Achievable, Recovery-related, and Measurable (A.R.M.); e.g., complete a 15 minute daily walk.
- Continue or modify opioid treatment with demonstrated benefit and **discontinue when the risks** of side effects, misuse, addiction, and/or overdose **outweigh the benefit**.
- **Engage family and other key individuals** when possible to support patient-obtained information.

S CREEN FOR APPROPRIATE OPIOID USE AND THE CONTINUED NEED FOR OPIOID THERAPY including prescription drug monitoring reports (e.g., **SCRIPTS** reports)

- **Assess and document risk of opioid misuse** with subjective and objective measures **PRIOR to prescribing**, and individualize level of monitoring and possible co-management to match the identified risk.
- **Review SCRIPTS reports prior to prescribing any C-II and every three months thereafter** to help identify potential opioid misuse/abuse and support safe prescribing and dispensing.
- Continue to assess, monitor, and document risk of opioid misuse/abuse (including input from family members and key contacts) since **risk level can change for any patient at any point**.
- **Adjust ongoing monitoring** plan (e.g., **SCRIPTS** report review, frequency of visits, urine drug tests, pill counts) **to match risk level** and co-manage or refer for addiction treatment as needed.



CONSIDERATIONS FOR REVIEWING SOUTH CAROLINA PRESCRIPTION

A SCRIPTS report is one tool to help confirm a patient's controlled substance

WHAT IF:

APPARENTLY GOOD RESULTS (1 PHARMACY, 1 OPIOID PRESCRIBER)¹

- Do the results match clinical evaluations (e.g., urine drug test) and patient interviews?
- Consider non-adherence behaviors not captured in results (e.g., bingeing, running out early).

WHAT IF:

TOTAL MORPHINE MILLIGRAM EQUIVALENTS PER DAY (MME/day)² SUGGESTS CONCERN FOR ADVERSE EVENTS OR OVERDOSE^{3,4}

- Before increasing dose to ≥ 50 MME/day, carefully assess if the diminishing benefit in pain or function outweighs the increasing overdose risks.
- More recent guidelines recommend additional precautions when prescribing ≥ 50 MME/day, including more frequent follow-up, offering naloxone,^{4,5} and providing overdose prevention education to patients and caregivers.
- Guidelines do not recommend abrupt tapering or discontinuation of opioids. For patients already on higher opioid daily doses, carefully weigh risks and benefits of tapering or continuing opioid dose.

All homes that contain opioids carry some risk of overdose for the patient and others.

WHAT IF:

OVERDOSE RISK SCORE (ORS)⁶ SUGGESTS CONCERN FOR ADVERSE EVENTS OR OVERDOSE

- ORS indicates the risk of unintentional overdose death; the odds begin to increase sharply at a score of 200.⁶
- Look at the list of *Key Contributing Factors*⁷ to help identify potential patient risks.
- Use ORS^{6,7} as a signal to review the complete patient profile and speak with patient and family to identify factors not captured in SCRIPTS that can influence unintentional overdose (e.g., depression, respiratory conditions).

ORS alone is NOT sufficient information to decide to prescribe or refuse to prescribe medication.

Data suggest
co-prescribing naloxone
AND providing
overdose education to
patients, family, and
friends encourages safer
opioid use and reduces
overdose rate.

WHAT IF:

COMBINATION OF OPIOID AND OTHER CONTROLLED SUBSTANCE(S), ESPECIALLY BENZODIAZEPINES^{8,9}

- Pain guidelines concur benzodiazepines and opioids are high-risk combinations,⁴ especially in the elderly; many recommend against combination unless clearly indicated.
- Concurrent opioid and gabapentinoid use, especially higher doses of gabapentin (≥ 900 mg) or pregabalin (>300 mg) increases the risk of respiratory depression.¹⁰
- Is the combination clearly indicated? If clearly indicated, is the patient prescribed the lowest effective dose(s)? Monitor for respiratory depression, risk of falls, and risk vs. benefit for the combination.⁴
- What is the patient's level of functioning?

For more information on tapering
benzodiazepines visit:
https://bit.ly/benzo_tapering



WHAT IF:

OPIOID-ACETAMINOPHEN COMBINATION PRODUCT

- Remind patient about risks of "hidden acetaminophen" and alcohol found in some medications and OTC products.
- Counsel patient on risk of exceeding 4000 mg total daily acetaminophen dose. Consider 3000 mg total daily dose, especially if elevated liver function tests, known liver impairment, or older age; limit use to 2000 mg total daily dose in patients with alcohol use disorder or taking warfarin.

MONITORING PROGRAM (SCRIPTS) NARX REPORTS

(C-II – C-IV) drug history, adherence, or potential drug abuse/misuse/diversion

WHAT IF:

POTENTIAL ABERRANT BEHAVIOR (2 OR MORE PHARMACIES, 2 OR MORE OPIOID PRESCRIBERS)³

- Does it match clinical evaluations (e.g., urine drug test) and patient interviews?
- Consider differential diagnosis for possible inappropriate opioid use:

☐ **ADDICTION** - often characterized by behaviors that may include loss of control over drug use, craving, compulsive use, and continued use despite harm to health or relationships (See table at right)

Physical dependence and tolerance are normal physiologic adaptations to extended opioid therapy and are NOT the same as addiction.

☐ **PHYSICAL DEPENDENCE** - biologic adaptation to drug that results in abstinence syndrome (signs and symptoms of withdrawal) upon cessation, rapid dose reduction, and/or administration of antagonist

☐ **TOLERANCE** - a physiologic state of reduced effect over time from regular drug exposure in which increased dosage is needed to produce specific effect (*increase in dose and no increase in effect may mean opioid is ineffective*)

☐ **HYPERALGESIA** - increase in pain sensitivity that can be seen with rapid opioid dose escalation or high opioid dose (*consider if increase in pain with increase in dose*)

☐ **PSEUDO-ADDICTION** - aberrant drug-related behaviors driven by uncontrolled pain (*relief seeking vs drug seeking*) that are reduced by improved pain control

☐ **OTHER PSYCHIATRIC ILLNESSES** - such as anxiety, depression, PTSD, “chemical coping” (knowingly or unknowingly taking medications to decrease or numb negative emotions)

☐ **DIVERSION** - moving medications from legal/medically indicated users to illegal/unauthorized users

CONCERNING BEHAVIORS FOR ADDICTION

- Requests for increases in opioid dose
- Requests for specific opioid by name, “brand name only,” or allergic to all but the desired opioid
- Overwhelming focus on opioids during visits instead of underlying disease process
- Multiple office contacts regarding opioids
- Unwilling to follow through with recommended therapy/referrals (e.g., physical therapy)
- Running out early due to unsanctioned dose escalation
- Resistance to change therapy despite harm or negative consequences (e.g., over-sedation); unwilling to consider non-opioid therapy
- Concurrent alcohol or substance abuse
- Deterioration in function at home and work
- Opposition to monitoring (e.g., pill counts, UDT)
- Three or more requests for early refills
- Multiple “lost,” “spilled,” or “stolen” opioid prescriptions
- Multiple sources for opioids
- Illegal activities – forging prescriptions, selling opioid prescriptions
- Overdose

Adapted with permission: Boston University SCOPE of Pain Program www.scopeofpain.com

When patient behavior suggests concern for addiction, assess for Opioid Use Disorder (OUD). Patients with OUD often have poor outcomes when “kicked out” of care and typically respond better when care is “kicked up”. OUD is a manageable chronic disease, just like hypertension or diabetes; **consider offering medications for opioid use disorder (MOUD)** or referral for treatment.



If you are interested in learning more about MOUD at your practice, please visit https://bit.ly/tipSC_MOUD and/or attend Project ECHO Opioid Use Disorder Telementoring and Educational Sessions (https://bit.ly/MUSC_ECHO)

¹ Not all dispensed opioids require reporting to SCRIPTS, such as methadone dispensed from Opioid Treatment Programs (i.e., “methadone clinics”) or < 48-hour supply from emergency department.

² Morphine Milligram Equivalents (MME) is a mathematical conversion that standardizes risk evaluation of the different opioids.

³ Increased risk of opioid overdose-related death has been associated with 4+ opioid prescriptions, 4+ pharmacies, or total MME/day ≥ 100 .

⁴ Multiple guidelines agree on co-prescribing naloxone to anyone currently on chronic opioids in ANY ONE of the following higher risk groups: opioid dose ≥ 50 MME/day; concomitant benzodiazepine and opioid use; history of opioid overdose or substance use disorder; respiratory conditions (e.g., COPD, sleep apnea); mental health condition(s); excessive alcohol use; AND previously on chronic opioids with a lost tolerance to previous dose and at risk of resuming that dose using prescription or illicit drugs (e.g., opioid taper underway, recent release from prison or detoxification facility).

⁵ Multiple formulations and dosages of opioid overdose antidotes (e.g., naloxone, nalmefene) are now available; evidence suggests high-dose version of naloxone (8 mg) does not improve survival rates compared to 4 mg.

⁶ An ORS of 000 is an error reading meaning no ORS could be calculated.

⁷ Key Contributing Factors displayed and used in the ORS calculation include: > 6 opioid prescriptions dispensed; benzodiazepine-narcotics overlap; # of high-risk prescriptions dispensed; # of pharmacies where opioids/sedatives dispensed; total days supply of short-acting opioid prescriptions; and # of overlapping opioid/sedative dispensations.

⁸ Benzodiazepine and opioid medication labelings carry black box warnings highlighting the risks associated with concomitant use.

⁹ Lorazepam Milligram Equivalent (LME) values in SCRIPTS offer one way to compare sedative hypnotic medications for dose-related risk considerations.

¹⁰ Gabapentin is not a controlled substance in South Carolina; pregabalin is a C-V and not reported to SCRIPTS

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The information contained in this summary is intended to assist primary care providers in the management of chronic non-cancer pain in adults in the primary care setting. This information is advisory only and is not intended to replace sound clinical judgement, nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac, liver and renal impairment; debility; older adults; addiction; and pregnancy/breast-feeding).