Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain

Summary Version

Utah Department of Health
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David N. Sundwall, MD
Executive Director

Robert T. Rolfs, MD, MPH
State Epidemiologist

Erin Johnson, MPH
Program Manager

This is the summary version of the Utah Clinical Guidelines on Prescribing Opioids. To view the complete guidelines visit www.health.utah.gov/prescription or email useonlyasdirected@utah.gov to request that a complete copy be mailed to you.

Corresponding Author:

Robert T. Rolfs, MD, MPH

PO Box 142104
Salt Lake City, Utah, 84114-2104

phone (801) 538-6191
fax (801) 538-9923
email: rrolfs@utah.gov

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The tools found in this publication, as well as additional tools can be downloaded from: www.health.utah.gov/prescription

Summary of Recommendations

Opioid Treatment for Acute Pain

1) Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies will not provide adequate pain relief.

2) When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed based on the usual duration of pain severe enough to require opioids for that condition.

3) When opioid medications are prescribed for treatment of acute pain, the patient should be counseled to store the medications securely, to not share with others, and to dispose of medications properly when the pain has resolved in order to prevent non-medical use of the medications.

4) Long duration-of-action opioids should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted. Methadone is rarely if ever indicated for treatment of acute pain.

5) The use of opioids should be reevaluated carefully, including assessing the potential for abuse, if persistence of pain suggests the need to continue opioids beyond the anticipated time period of acute pain treatment for that condition.

Opioid Treatment for Chronic Pain

1) A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain.

2) Alternatives to opioid treatment should be tried (or adequate trial of such treatment by a previous provider documented), before initiating opioid treatment.

3) The provider should screen for risk of abuse or addiction before initiating opioid treatment.

4) When opioids are to be used for treatment of chronic pain, a written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function.[3]

5) The patient should be informed of the risks and benefits and any conditions for continuation of opioid treatment, ideally using a written and signed treatment agreement.

6) Opioid treatment for chronic pain should be initiated as a treatment trial, usually using short-acting opioid medications.

7) Regular visits with evaluation of progress against goals should be scheduled during the period when the dose of opioids is being adjusted (titration period).

8) Once a stable dose has been established (maintenance period), regular monitoring should be conducted at face-to-face visits during which treatment goals, analgesia, activity, adverse effects, and aberrant behaviors are monitored.

9) Continuing opioid treatment after the treatment trial should be a deliberate decision that considers the risks and benefits of chronic opioid treatment for that patient. A second opinion or consult may be useful in making that decision

10) An opioid treatment trial should be discontinued if the goals are not met and opioid treatment should be discontinued at any point if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated.

11) Clinicians treating patients with opioids for chronic pain should maintain records documenting the evaluation of the patient, treatment plan, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant behavior observed.

12) Clinicians should consider consultation for patients with complex pain conditions, patients with serious co-morbidities including mental illness, patients who have a history or evidence of current drug addiction or abuse, or when the provider is not confident of his or her abilities to manage the treatment.

13) Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use, and who are prepared to conduct the necessary careful monitoring.

Information Available in the Complete Guidelines

Cover Letter from Executive Director of Utah Department of Health

Acknowledgements

Disclosure of Funding

Background and Introduction

Summary of Recommendations

Methods

- Purpose and Target Audience
- Guideline Evidence Review
- Grading of the Evidence and Recommendations
- Panel Composition
- Recommendation Development Process
- Tools Development Process

Recommendations

- Opioid Treatment for Acute Pain
- Opioid Treatment for Chronic Pain

Tools

Tools to Use in Evaluating & Monitoring

- Pain Management Evaluation Tool
- Patient Pain and Medication Tracking Chart
- Sheehan Disability Scale
- Brief Pain Inventory Form
- Sample Treatment Plan for Prescribing Opioids
- SF-12

Tools to Screen for Risk of Complications

- COMM
- SOAPP-R
- Opioid Risk Tool
- Urine Drug Testing Devices
- Signs of Substance Misuse
- Checklist for Adverse Effects, Function, and Opioid Dependence

Informational Tools

- Federal Guidelines on Proper Disposal of Prescriptions
- Non-Opioid Pain Management Tool
- Absolute Contraindications to Opioid Prescribing
- Strategies for Tapering & Weaning
- Information for Patients—Opioid Analgesics for Non-Cancer Pain
- The Role of Methadone in the Management of Chronic Non-Malignant Pain
- Dosing Guidelines

Utah-Specific Tools

- Directory of Resources
- Utah's Tamper Resistant Requirements

These tools can be downloaded from:
www.health.utah.gov/prescription

To view the complete Utah Clinical Guidelines on Prescribing Opioids or for printer-friendly copies of the tools visit
www.health.utah.gov/prescription

Patient Pain and Medication Tracking Chart

Name	ID#	Date
Pain Dxs:		DOB
		Gender M/F

Directions: At the end of each day use this log to record your function, pain, sleep and alcohol/drug use. This will be used by your provider to properly adjust your medications to obtain optimal benefit and to minimize risk to your health and safety.

Date	Medications	# Pills/day	Pain [1] (0-10)	Function [2] (0-10)	# Hours Slept	Alcohol or Drugs used

[1] Pain Scale: 0 = no pain, 5 = moderate pain, 10 = worst pain imaginable

[2] Function Scale: 0 = no limitations, 5 = limitations (difficulty working, lifting, exercising, or conducting daily living activities, 10 = severe limitations (unable to work, conduct daily living activities, lift or exercise)

Pain Management Work up and Risk Assessment

Name	ID#	Date
Pain Dxs:		DOB
		Gender M/F

Opiod Risk Tool[1]	Mark all that apply	Score if Female	Score if Male
Family Hx of Substance Abuse			
Alcohol	[ ]	1	3
Illeg Drugs	[ ]	2	3
Prescrp	[ ]	4	4
Personal Hx of Substance Abuse			
Alcohol	[ ]	3	3
Illeg Drugs	[ ]	4	4
Prescrp	[ ]	5	5
Hx of Preadolescent Sexual abuse	[ ]	3	0
Age 16-45 yrs	[ ]	1	1
Depression	[ ]	1	1
Psychiatric Disease			
ADD	[ ]	2	2
OCD	[ ]	2	2
Bipolar	[ ]	2	2
Skiz	[ ]	2	2
Total	**[ ]**		

Additional Risk Assessments		**Comments**
Drug Screen	Y/N	
DOPL Screen	Y/N	
Risk of Obstructive Sleep Disorder	Y/N	
Obesity Y/N	BMI =	
Hx of Sleep Apnea	Y/N	

Baseline Measures	**Comments**
Analgesia[2] (Pain 0-10)	
Activity[3] (Function 0-10)	
Adverse Events Y/N	

Psychiatric Disease		**Comments**
Aberrant Behavior	Identify	

Consultation/Referral: **Comments**

If receiving Morphine equivalent ≥ 120 mg/day or Methadone ≥ 50 mg/day **then** Sleep Apnea Test Y/N

If receiving Methadone ≥ 50 mg/day **then** EKG (Qt) Y/N

Treatment agreement discussed and signed by patient **Date**

Patient Goals			Identify aberrant behavior which indicates discontinuation
Analgesia Pain[2] (0-10)	Activity - Function[3] (0-10)	Adverse Events - #	

[1] Opioid Risk Tool (Webster & Dove, 2007) - low risk (routine care), moderate risk (increased monitoring frequency) high risk (consider referral to Substance Abuse and/or Pain Management specialists)

[2] Pain Intensity 0 = no pain, 5 = moderate pain, 10 = worst pain imaginable

[3]Activity Function 0= no limitations, 5 = limitations (difficulty working, lifting,exercising, or conducting daily living activities) 10 = severe limitations (unable to work, conduct daily living activities, lift, or exercise)

Pain Management Follow-Up

Name	ID#	Date
Pain Dxs:		DOB Gender M/F

Initation of Trial			**Start Date**			**Review Date**	
Visit Frequency [1] Date	**Analgesia - Pain (0-10)**	**Activity - Function (0-10)**	**Adverse Events - #**	**Aberrant Behavior - Identify**	**DOPL Check**	**Random Drug Screen**	**Comments (Date)** **Discontinuation Change (Date)**
Titration - Visit = 2 - 4 weeks							
Visit Frequency [1] Date	**Analgesia - Pain (0-10)**	**Activity - Function (0-10)**	**Adverse Events - #**	**Aberrant Behavior - Identify**	**DOPL Check**	**Random Drug Screen**	**Comments (Date)** **Discontinuation** **Change (Date)**
Maintenance - Visit = Quarterly							
Visit Frequency [1] Date	**Analgesia - Pain (0-10)**	**Activity - Function (0-10)**	**Adverse Events - #**	**Aberrant Behavior - Identify**	**DOPL Check**	**Random Drug Screen**	**Comments (Date)** **Discontinuation Change (Date)**

[1] Monitoring Frequencies (Webster 2007)
Low Risk (0-3) - Routine
Mod Risk (4-7) - Bi-Weekly
High Risk ≥ 8 - Weekly

Treatment Plan Using Prescription Opioids

Patient name: _____

Prescriber name: _____

THE PURPOSE OF THIS AGREEMENT IS TO STRUCTURE OUR PLAN TO WORK TOGETHER TO TREAT YOUR CHRONIC PAIN. THIS WILL PROTECT YOUR ACCESS TO CONTROLLED SUBSTANCES AND OUR ABILITY TO PRESCRIBE THEM TO YOU.

I (patient) understand the following (initial each):

_____ Opioids have been prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including return to work. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.

Goal for improved function: _____

_____ Opioids are being prescribed to make my pain tolerable but may not cause it to disappear entirely. If that goal is not reached, my physician may end the trial.

Goal for reduction of pain: _____

_____ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to myself or others.

_____ Using opioids to treat chronic pain will result in the development of a physical dependence on this medication, and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

_____ There is a risk that opioid addiction can occur. Almost always, this occurs in patients with a personal or family history of other drug or alcohol abuse. If it appears that I may be developing addiction, my physician may determine to end the trial.

Continued on other side.

I agree to the following (initial each):

_____ I agree not to take more medication than prescribed and not to take doses more frequently than prescribed.

_____ I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.

_____ I agree not to share, sell, or in any way provide my medication to any other person.

_____ I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my doctor may check the Utah Controlled Substance Database at any time to check my compliance.

_____ I agree not to seek or obtain **ANY** mood-modifying medication, including pain relievers or tranquilizers from **ANY** other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this agreement. I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

_____ I agree to refrain from the use of **ALL** other mood-modifying drugs, including alcohol, unless agreed to by my prescriber. The moderate use of nicotine and caffeine are an exception to this restriction.

_____ I agree to submit to random urine, blood or saliva testing, at my prescriber's request, to verify compliance with this, and to be seen by an addiction specialist if requested.

_____ I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time.

I understand that ANY deviation from the above agreement may be grounds for the prescriber to stop prescribing opioid therapy at any time.

_____ _____

Patient Signature Date

_____ _____

Prescriber Signature Date

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	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		**[ ]**		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8

Low-risk patients should be monitored at a level that could be described as routing. This does not mean these individuals are not monitored with vigilance and care, only that no extraordinary measures are required.

- Explain the standard treatment agreement; both provider and patient should sign it.
- Schedule regular follow-up visits (monthly at first).
- Set the frequency of medication refills (monthly for the first 6 months).
- Perform initial urine (or other) drug screening.
- Communicate with pharmacies or obtain initial reports from prescription-monitoring programs (where available) and prior medical providers.
- Document every patient and clinician interaction.
- Continually review the Four A's during return visits.
- Consultations with specialists are not required.
- Medication type: adequate analgesia, no restrictions.

Moderate risk for drug abuse calls for another layer of vigilance in addition to the routine monitoring established for low-risk patients:

- Regular follow-up visits and prescriptions refills should occur every 2 weeks initially.
- Observe patients for signs of complicating co morbid diagnoses, such as anxiety, depression, or a sleep disorder.
- Consider referring the patient for evaluation by pain management and psychiatric specialists.
- Conduct regular checks (every 6-12 months) of your state's prescription monitoring database, if available, or consult with the patient's pharmacist.
- Visit with the patient's family members or other third parties to verify the patient's accounts and for evidence of environmental influences.
- Institute random urinalysis (or another screening method) to confirm compliance with medication levels.
- Consider checking leftover medications to verify their quantity.
- Consider limiting the use of rapid-onset analgesics.

High-risk patients require the following measures of intense monitoring in addition to those required by the low-risk and moderate-risk groups:

- Schedule regular follow-up visits more frequently than usual. If problems develop, shorten the treatment interval to weekly.
- Prescribe just enough medication to last until the next appointment and ensure that prescription refills are contingent upon attendance.
- Typically, psychiatric and addiction-medicine consultations are required. Consider consultation with a pain management specialist. Coordinate treatment.
- Conduct regular urine (or other) drug screenings in addition to some unexpected screenings.
- Consider using blood screenings.
- During every visit, count the patient's leftover medication.
- Consult a prescription database (if available) more frequently.
- Strongly enforce the treatment agreement.
- Avoid prescribing rapid-onset analgesics and consider limiting short-acting analgesics.

The 3 risk categories help make treatment decisions easier but should not be used to label patients. Remember that the need to monitor for aberrant behavior is ongoing, and patients can move from 1 risk group to another throughout the course of treatment. For example, a patient initially assessed as low risk may later display multiple aberrant behaviors in response to a deteriorating physical condition or life stresses.

In general, exhibiting more than 3 mildly aberrant behaviors during 1 year or exhibiting 1 egregious behavior should cause a patient to move to a higher risk category and to be monitored more closely. If patients remain in the low-risk category for 6 months, the interval between visits and refills of medication can be increased. Eventually, when patients have remained in the low-risk category for 1 year, refills that last for 3 months are common.

Utah Directory of Resources

Consultation and Referral

Identifying Pain Management, Mental Health, and Substance Abuse Providers

1) The 211 Information and Referral Bank
http://www.informationandreferral.org
The 211 Info Bank strives to ease the process of locating available and appropriate resources.

2) Utah Cares: State Online Services
https://utahcares.utah.gov/erepucpub/en/ServiceSupplier_searchPage.do?__o3rpu=ScreenReferralHomePage.do
This site allows you to do a search on providers by type and county.

3) Utah Resources Hotline: 2-1-1
Dial 2-1-1 and someone can direct you to providers by specialty in any county in Utah.

4) Utah Medicaid Pain Management Providers
http://health.utah.gov/medicaid/pharmacy/documents/chronic.php

5) Utah Mental health providers
http://mentalhealth.samhsa.gov/databases/facility-search.aspx?state=UT&fullname=Utah

6) Substance Abuse Providers
http://www.dsamh.utah.gov/locationsmap.htm
This link allows you to seek providers by location using an interactive map.

Referral Services

1) Substance Abuse Hotline: 1-866-633-HOPE (4673)

2) Utah Medicaid Restriction Program
http://health.utah.gov/medicaid/pharmacy/Restriction/restriction.php

3) University of Utah Assessment & Referral Services
Assessment & Referral Services is a University of Utah Clinic within the Department of Psychiatry that provides high-quality, objective substance abuse assessments and referrals for individuals with possible substance abuse problems.

Laws Governing Use of Controlled Substances

Federal/DEA laws – www.dea.gov

1) Practitioner Manual
http://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf
This manual has been prepared by the Drug Enforcement Administration to assist practitioners and other registrants authorized to prescribe, dispense, and administer controlled substances. A summary of the act can be found below in Appendix C.

2) Schedules of Controlled Substances
http://www.access.gpo.gov/nara/cfr/waisidx_01/21cfr1308_01.html
Schedules of controlled substances can be found in Title 21, Chapter II.

3) Prescriptions
http://www.access.gpo.gov/nara/cfr/waisidx_01/21cfr1306_01.html
Contains the rules governing the issuance, filling and filing of prescriptions pursuant to section 309 of the Act (21 U.S.C. 829)

Utah Directory of Resources

4) Administering and Dispensing of Controlled Substances
http://edocket.access.gpo.gov/cfr_2001/aprqtr/pdf/21cfr1306.07.pdf
Persons who are entitled to fill prescriptions are described in this document found at the link above.

State of Utah Laws – State legislation and regulations

1) Utah Medical Practice Act Rules
http://www.dopl.utah.gov/laws/R156-67.pdf
2) Utah Controlled Substance Act 58-37
http://www.dopl.utah.gov/laws/58-37.pdf
3) Utah Controlled Substance Rules R156-37
http://www.dopl.utah.gov/laws/R156-37.pdf
4) Reporting Prescription Fraud and/or Prescription Related Crime
http://www.urxnet.org/ or http://www.urxnet.org/tip/addtip.asp
5) Division of Occupational and Professional Licensure
http://dopl.utah.gov/
6) Utah Controlled Substance Database
https://csdb.utah.gov/
7) Model Policy for the Use of Controlled Substances for the Treatment of Pain—Federation of State Medical Boards
http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf
The Model Policy, which was adopted by the Utah Medical Board of Examiners, is designed to communicate certain messages to licensees: that the state medical board views pain management to be important and integral to the practice of medicine; that opioid analgesics may be necessary for the relief of pain; that physicians have a responsibility to minimize the potential for the abuse and diversion of controlled substances; and that physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes. This policy is not meant to constrain or dictate medical decision making.

*If there are legal or workplace concerns, it is recommended that patients go to the industrial clinic

Additional Tools

Pain Assessment Tools

1) Beckman Research Institute
http://prc.coh.org/pain_assessment.asp

2) Tools from Utah Clinical Guidelines on Prescribing Opioids
http://health.utah.gov/prescription/

3) Inflexxion
http://painedu.org/

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