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Clinical Associate Professor
UNMHSC College of Pharmacy

Objectives
At the end of this presentation, the participant will be able to do the following when prescribing opioid medication for chronic non cancer pain (CNCP):
- Discuss the Boards of Medicine, Nursing & Pharmacy requirements for safe prescribing of opioid medications
- Understand the Boards of Medicine & Nursing requirements for drug testing
- Discuss the Boards of Medicine & Nursing requirements for Controlled Substance Agreements & surrounding controversy
- Discuss the Board of Pharmacy PMP program and requirements
- Understand what needs to be documented in a patient’s chart as required by the Boards of Medicine & Nursing

Use of Opioids in Chronic Pain: Balancing Act
• Pain as the 5th vital sign
• Starting in 2001, the Joint Commission officially recognized that pain is a major health problem and "patients have the right to appropriate assessment and management of pain"
A Balancing Act: Public Health

• A crisis of abuse of prescription opioid medication
• New Mexico is #3 in U.S. in accidental OD rates with prescription opioid medication
• Yet NM providers prescribe less than the national median amount of opioid medication

A Balancing Act: Patient’s Expectations

• Being pain free
• “Magic bullet” medications
• Unlimited supply of medications
  ➢ opioids
• Not having to do any work
  ➢ physical therapy
  ➢ behavioral health
• No consequences for their decisions
  ➢ “being honest”

A Balancing Act: Provider’s Realities

• Incidence of alcoholism and addiction in the general population is 5%-10%
• One addict affects 7-10 people
• Prevalence of current or past substance use disorders in patients receiving chronic opioids for CNCP may be ~ 40% or higher
• The principles of chronic medication management are often forgotten when managing opiate medication
⇒ clash of provider & patient values
Basic Concepts of Prescribing Opioids: Efficacy

- Principles of medication management & prescribing
  - evidenced based medicine
  - efficacy and safety
  - use of corticosteroids as an analogy

Controversy: Opiates for CNCP?

- There is not consensus among expert recommendations regarding the efficacy of opiate use in CNCP, for example:
  - Chou R et al. 2009: concludes chronic opioid therapy (COT) can be effective in selected patients
  - Manchikanti L et al. 2011: concludes there is only weak evidence for the use of COT
- There is insufficient evidence to determine the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms, such as overdose, mortality, and possibly fractures and cardiovascular events...

Basic Concepts of Prescribing Opioids: Safety

- Sleep apnea
- Opioid induced hyperalgesia
- Dangerous drug-drug combinations
  - benzodiazepines
  - carisoprodol
- Hypogonadism
Place of Opioids in the Treatment of Chronic Pain

• Guidelines for starting opioids by indication, according to the American Academy of Pain Medicine
• Neuropathic, Chronic Back/Muscle, Inflammatory, or pain from Mechanical/Compressive Etiology:
  ➢ ONLY AFTER ALL NON-OPIOID MEDICATIONS HAVE BEEN MAXIMIZED

Prior to Initiating Opioid Medication

• Per NM BOM: NMAC16.10.14 & NM BON: 16.12.9
  – History & PE
  – Non opioid medication maximized
  – SOAPP R screening test
  – Controlled Substance Agreement (CSA)
  – Review of NMBOP PMP report
  – Baseline UDM
  – Discuss risks and benefits of using controlled substances w/patient

Initiating Opioid Medication

• Start low and go slow
• Start on short acting (SA) opioid
• Reassess in ~ 2 weeks
• Caution
  – Fibromyalgia, Headache, IBS
Practical/General Dosage Range Guidelines for Use of Opioids in CNCP (MME = Morphine Milligram Equivalent)

<table>
<thead>
<tr>
<th>Level</th>
<th>Daily MME Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>5 – 30 per day</td>
</tr>
<tr>
<td>Moderate</td>
<td>35 – up to 70</td>
</tr>
<tr>
<td>Moderately High</td>
<td>75 – up to 100</td>
</tr>
<tr>
<td>High</td>
<td>100 – up to 120</td>
</tr>
<tr>
<td>Very High</td>
<td>&gt; 120 MME (almost never appropriate)</td>
</tr>
</tbody>
</table>

Opioid Equianalgesic Doses:

- **Caution with Methadone**
  - Variable half-life (8-59 hours) and duration (6-8 hours)
  - Dose q 6-12 hours
  - Multiple drug interactions
  - Avoid with alcohol, azole antifungals, thioridazine
  - Can ↑ QTc Interval @ = 100mg/day
  - If ↑ QTc, Decrease dose
  - Can accumulate in the elderly
  - No changes in dose until 5-7 days after starting methadone
**Methadone (possible) Equianalgesic Doses**

<table>
<thead>
<tr>
<th>Total Daily Dose Oral Morphine</th>
<th>EPERC Conversion (MSO: Methadone)</th>
<th>% of MSO Dose (FDA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100 MME</td>
<td>3:1</td>
<td>20-30%</td>
</tr>
<tr>
<td>101-300 MME</td>
<td>5:1</td>
<td>10-20%</td>
</tr>
<tr>
<td>300-600 MME</td>
<td>10:1</td>
<td>8-12%</td>
</tr>
<tr>
<td>600-800 MME</td>
<td>12:1</td>
<td>5-10%</td>
</tr>
<tr>
<td>800-1000 MME</td>
<td>15:1</td>
<td>5-10%</td>
</tr>
<tr>
<td>&gt; 1000 MME</td>
<td>20:1</td>
<td>&lt; 5%</td>
</tr>
</tbody>
</table>

**Fentanyl Patch Cautions**

- Fentanyl is ≈ 100x > potency than morphine
  - Not for opioid naive patients
- Takes 24 hours before full effect is known, therefore not for breakthrough or acute pain
- Fentanyl is highly lipophilic: caution if ↑ BMI
- Different generic products are not truly interchangeable
- Can only titrate in 3 day increments

**Approximate Fentanyl Patch Equianalgesic Doses:**

<table>
<thead>
<tr>
<th>Fentanyl Patch (mcg/hour)</th>
<th>Oral Morphine: MME per 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.5</td>
<td>30</td>
</tr>
<tr>
<td>25</td>
<td>60</td>
</tr>
<tr>
<td>50</td>
<td>120</td>
</tr>
<tr>
<td>75</td>
<td>180</td>
</tr>
<tr>
<td>100</td>
<td>240</td>
</tr>
</tbody>
</table>
Reassessment of Opioid Medication Regimen

4 A’s of monitoring opiate therapy

• Analgesia
• activities of daily living
• adverse effects
• aberrant drug-related behaviors

Reassessment of Opioid Medication Regimen

• Does current opioid dose make sense; ie: 100-120 MME
  ➢ Is medication strong enough?
    ✓ If Not strong enough & Not lasting long enough
    ↑ dose
  ➢ Does medication last long enough?
    ✓ If Strong enough but Not lasting long enough
    ↓ dose interval
• ALWAYS Pause & think
• Consider adherence

Continuation of Opioid Medication

➢ Goals met, SA opioid is strong enough & lasts long enough, if using ≤ 6 doses daily
  ➢ Continue as is
Continuation of Opioid Medication

- Goals met but using ≥ 6 doses daily and/or patient goes without opioid for extended time
  - Does current opioid dose make sense? i.e. ≤ 120 MME daily
  - Option to change to long acting (LA) opioid to help with adherence
  - Validity of the practice of using LA opioid and short acting opioid together
  - The rationale for "breakthrough medication"

Continuation of Opioid Medication

Response to current opioid is inadequate and/or patient is not tolerating current opioid

- Does current opioid dose make sense; i.e. ≤ 120 MME
- Consider Options: Could change to another Opioid
- Rotate to another opioid using equianalgesic dose and decrease by 30% for incomplete cross tolerance

When Good Intentions Lead To…..

- Undesired Outcomes of Opioid Use
  - Physical Dependence
  - Tolerance - larger doses for same effect
  - Addiction vs Pseudo-Addiction
  - Withdrawal
  - Hyperalgesia
  - Aberrant Medication Related Behavior
Opioid Therapy: Judging Initial Risk for Aberrant Medication Related Behavior

Most important predictive factors:
- prior history of substance abuse
- family history of substance abuse
- major psychiatric pathology
- decreasing age

Screening for risk

<table>
<thead>
<tr>
<th>Acronym of tool</th>
<th>Number of questions</th>
<th>Completion</th>
<th>Time to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOAPP®-R</td>
<td>24 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
<tr>
<td>DIRE</td>
<td>7 items</td>
<td>Clinician</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>ORT</td>
<td>5 items</td>
<td>Clinician</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>COMM (current use)</td>
<td>40 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
<tr>
<td>CAGE (current use)</td>
<td>4 items</td>
<td>Self-report or clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
</tbody>
</table>

Identifying Aberrant Medication-Related Behavior

Portenoy and Payne's Aberrant Behavior

1. Selling prescription drugs
2. Forging prescriptions
3. Stealing drugs
4. Injecting oral formulations
5. Obtaining prescription drugs from non-medical sources
6. Concurrently abusing alcohol/illicit substances
7. Escalating doses on multiple occasions despite warnings
8. "Losing" prescriptions on multiple occasions
9. Repeatedly seeking prescriptions from other providers/ED without informing the provider or after warnings to desist
10. Evidence of deteriorating function due to drug use

Identifying Medication Related Aberrant Behavior

- Clinical judgment alone is inadequate to identify aberrant behavior
- No single tool is adequate to identify or predict aberrant drug related behavior
- Combining a tool (SOAPP, SOAPP-R, ORT) with a clinical interview, drug testing, and review of PMP reports maximizes likelihood of identifying aberrant behaviors

Identifying Aberrant Medication-Related Behavior

- Should be a data driven process
  - Treatment agreements
    - mandated by state professional boards
    - “suggested” by FDA REMS guidelines
  - Urine Drug Screens
    - mandated by state professional boards
    - “suggested” by FDA REMS guidelines
  - NMBOP PDMP program
    - signing up & access is now mandated by state regulation
  - Pharmacy records
  - Previous chart notes
  - Missed appointments
  - Experience & intuition

Controlled Substance Agreements (CSA)

- An educational tool explicitly stating patient and clinician responsibilities
- Required by New Mexico Medical & Nursing Boards
- Recommended in American Society of Interventional Pain Physicians guidelines
- Recommended by FDA REMS Guidelines
- Conflicting data on efficacy
Positive effects of chronic opiate therapy do not remain static & can be effected by changes in:
  – underlying disease state
  – changes in psychological &/or social circumstances
UDS helps providers identify patients who:
  – are benefiting from chronic opiate therapy
  – might need more structure
  – are receiving other services (ie: addiction tx)
  – have behavior where the use of opiates outweighs the benefits of opiate therapy
  – Per NM BOM & BON: “recommended drug screening when other factors suggest an elevated risk of misuse or diversion”


Urine Drug Testing: APS Guidelines

Fear of damaging provider-patient relationship
Always make sure the test ordered will test for the medication in question
Always document when patient last took a dose of the medication being tested
High risk medication, not high risk patients
  ➢ Good data drives good therapy

Types of Urine Drug Testing

<table>
<thead>
<tr>
<th>In-office, point-of-care, or lab-based IA test</th>
<th>Laboratory test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less specific and sensitive</td>
<td>Highly specific and sensitive</td>
</tr>
<tr>
<td>Results within minutes</td>
<td>Results in hours to days</td>
</tr>
<tr>
<td>Detects drug classes and few meds, illicit substances</td>
<td>Measures concentrations of all medications, illicit substances, and metabolites</td>
</tr>
<tr>
<td>Guidance for preliminary treatment decisions</td>
<td>Definitive identification and analysis</td>
</tr>
<tr>
<td>Cross-reactivity common: More false positives</td>
<td>False-positive results rare</td>
</tr>
<tr>
<td>Higher cutoff levels: More false negatives</td>
<td>False-negative results rare</td>
</tr>
</tbody>
</table>
Urine Drug Monitoring

• Importance of metabolites
  - hydrocodone is primarily metabolized to hydromorphone
  - morphine is primarily metabolized to 3 or 6 glucuronide metabolite
  - oxycodone is primarily metabolized to oxymorphone
  - Heroin
    - codeine & morphine, 6-MAM

• Know common interacting medications
  - bupropion, pseudoephedrine which can give false positive for amphetamines
  - certain antibiotics can give false positive for cocaine

Windows of Detection in Urine

- Indicates how long after administration a person excretes the drug and/or its metabolite(s) at a concentration above a specific test cutoff concentration
- 1 to 3 days for most drugs and metabolites

<table>
<thead>
<tr>
<th>Drug/Drug Class</th>
<th>Approximate Window of Detection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>3-5 days</td>
</tr>
<tr>
<td>THC*</td>
<td>Up to one month</td>
</tr>
<tr>
<td>Benzodiazepines*</td>
<td>1-3 days</td>
</tr>
<tr>
<td>Opioids*</td>
<td>~3 days</td>
</tr>
<tr>
<td>Cocaine (benzoylcegonine metabolite)</td>
<td>2-3 days</td>
</tr>
</tbody>
</table>

*Long-term use of lipophilic drugs or longer-acting benzodiazepines can extend window of detection.
Sources of False-Positive Results

Immunoassay Testing

Board of Pharmacy Prescription Monitoring Program

- Per the NM BOP:
  - “The New Mexico Prescription Monitoring Program (PMP) accumulates Schedule II-V controlled substance prescription and dispensing information into a restricted access online database in order to meet its mission to reduce the diversion of these controlled substances while serving as a valuable tool for legitimate medical practice and patient care”

- Per the NMBOM & BON
  - “The intent of the New Mexico medical board in requiring participation in the PMP is to assist practitioners in balancing the safe use of controlled substances with the need to impede illegal and harmful activities involving these pharmaceuticals.”
    - NM BOM 16.10.14.10
    - NM BON 16.12.9.9

REGISTRATION FOR ACCESS TO PRESCRIPTION INFORMATION

- Practitioner w/ individual DEA number
- Submit a hard copy written, signed and notarized application
- After verification of submitted information, a username and password will be issued to the practitioner
- One surrogate per practitioner account is authorized for an agent of the practitioner

- NM BOP 16.19.29.14
- NM BON 16.12.9.9
- NM BOM 16.10.14.10
Requirements for Chart Notes & Record Keeping

• Complete and accurate records of care provided and drugs prescribed shall be maintained.
• For controlled substances: the name of the drug, quantity, prescribed dosage and number of refills authorized shall be recorded.
• Prescriptions for opioids shall include indications for use
• Periodically review the course of treatment for chronic pain, the patient’s state of health, and any new information about the etiology of the chronic pain at least every six months

CNCP Management for Patients with Substance Use Disorders (NM BOM)

• CSA
• Appropriate consultation
• Drug testing w/ elevated risk of misuse or diversion
• Re-evaluated at appropriate intervals; at least every 6 months
  – NM BOM 16.10.14.8

CNCP Management for Patients with Substance Use Disorders (NM BON)

• CSA
• Drug screen prior to initiating therapy
• If concern for misuse develops patient will be sent for appropriate consultation and re-evaluated at appropriate intervals
  – NM BON 16.12.9.8
Do's & Don'ts With Opioid Medication

**• DO**
- Emphasize the importance of sustained improvement in functional levels allowed by opioids
- Describe opioids as having potential to "take the edge off" of the pain to allow greater function

**• DO NOT**
- Treat the Pain Scale ratings made by the patient (unclear value in chronic pain)
- Aim to remove all pain (to help patient "be out of pain", "to have the pain gone", to be "pain free")

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**Do's & Don'ts With Opioid Medication**

**• DO**
- START with low dose short-acting, perhaps 2-3 tablets per day as needed
- Systemize decision process when filling or refilling opiate Rx
- Remove stigma

**• DO NOT**
- Use higher dose short acting medications routinely > 6 doses daily
- Use opioid doses of 100-120 MME daily unless you pause and think
- Use combination of benzodiazepines & opioid
- EVER use Soma® (carisoprodol) – NEVER EVER

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**What I’m Not Saying; What I AM Saying**

**• What I AM NOT saying**
- Do not use opioids
- Opioids are bad drugs

**• What I AM saying**
- THINK when prescribing opioids
T.H.I.N.K

- T: take advantage of all resources
  - UDS, BOP PMP reports
- H: have data in hand
  - VAS (function, pain, sleep), UDS, BOP PMP reports
- I: intuition
  - SARS
- N: “NO” is a valid answer
  - do the NEXT right thing
- K: know the basics of chronic medication management
  - federal, state & local laws
  - Drug-Drug Interactions:
    - Opioid-Benzodiazepine
    - Opioid-Carisoprodol

Conclusions

- As with any medication utilized for chronic disease therapy, use of opioids is a double-edged sword
- Approach the use of Chronic Opioid Therapy in CNCP the same as any other chronic medication used in any other chronic disease state
- As with any medication, used for any chronic disease condition, safe and effective opioid therapy requires careful assessment of goals for therapy & ADRs, re-assessment
- A systematic, data driven approach to prescribing & monitoring opioid therapy should be used to decrease any personal bias
- Aberrant drug taking behavior is a continuum of behaviors and a predictable adverse event of opioid therapy