

# Pain Management and Opioids: Balancing Risks and Benefits

PRESENTED BY  
CO\*RE, THE COLLABORATION FOR  
REMS EDUCATION



UPDATED 2019



# FACULTY INFORMATION



INSERT CO\*RE  
PARTNER LOGO

## BIO:

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# ACKNOWLEDGMENTS

Presented by **[Insert Partner Name]**, a member of the Collaborative for Risk Evaluation and Mitigation Strategy (REMS) Education (CO\*RE), nine interdisciplinary organizations working together to improve pain management and prevent adverse outcomes.

This activity is supported by an independent educational grant from the Opioid Analgesic REMS Program Companies (RPC). Please see [this document](#) for a list of REMS Program Companies. This activity is intended to be fully compliant with the Opioid Analgesic REMS education requirements issued by the U.S. Food and Drug Administration.

# CO\*RE COLLABORATION





# FACULTY ADVISORY PANEL



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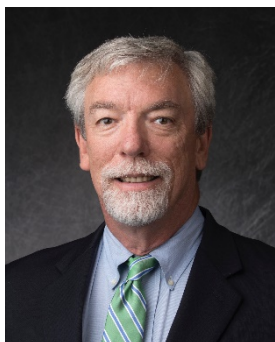
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NO CO\*RE FACULTY HAS ANY  
RELEVANT FINANCIAL  
RELATIONSHIPS

## BY THE END OF THIS SESSION YOU WILL BE ABLE TO

- Describe the *pathophysiology of pain* as it relates to the concepts of pain management.
- Accurately assess patients in pain.
- Develop a safe and effective pain *treatment plan*.
- Identify evidence-based *non-opioid options* for the treatment of pain.
- Identify the risks and benefits of *opioid therapy*.
- *Manage* ongoing opioid therapy.
- Recognize behaviors that may be associated with *opioid use disorder*.





# WHY ARE WE HERE?

## CO\*RE STATEMENT

Misuse, abuse, diversion, addiction, and overdose of opioids in the United States have created a serious public health epidemic.

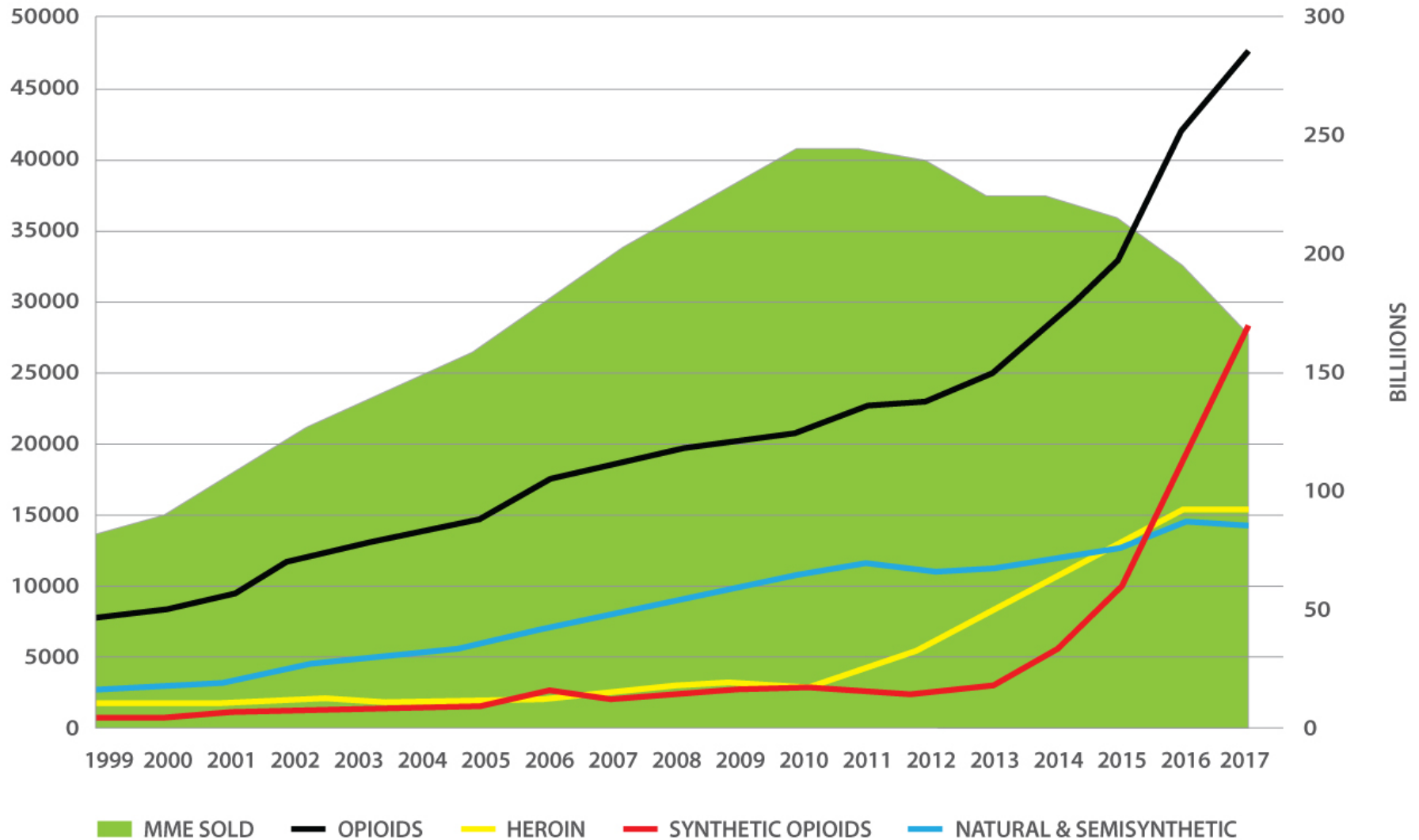
When prescribed well, and used as prescribed, opioids can be valuable tools for effective pain management.

There is potential for unintended consequences of inadequately managed pain from far-reaching prescribing restrictions.

This course is in alignment with the FDA Opioid Analgesics REMS Education Blueprint.

This course does not advocate for or against the use of opioids. We intend to help healthcare providers manage pain without putting vulnerable patients at risk for misuse or opioid use disorder. The goal is to keep our patients, our communities, and ourselves SAFE.

# PRESCRIBING PATTERNS AND OPIOID-RELATED DEATHS



# OPIOID ANALGESICS ARE SCHEDULE II SUBSTANCES



SCHEDULE	DESCRIPTION	EXAMPLES
I	High potential for abuse; no currently accepted medical use	Heroin, LSD, cannabis, ecstasy, peyote
II	High potential for abuse, which may lead to severe psychological or physical dependence	Hydromorphone, methadone, meperidine, oxycodone, fentanyl, morphine, opium, codeine, hydrocodone combination products
III	Potential for abuse, which may lead to moderate or low physical dependence or high psychological dependence	Products containing $\leq 90$ mg codeine per dose, buprenorphine, benzphetamine, phendimetrazine, ketamine, anabolic steroids
IV	Low potential for abuse	Alprazolam, benzodiazepines, carisoprodol, clonazepam, clorazepate, diazepam, lorazepam, midazolam, temazepam, tramadol
V	Low potential for abuse	Gabapentin, pregabalin, cough preparations containing $\leq 200$ mg codeine/100 ml

Complete list of products covered under the Opioid Analgesic REMS available at: <https://opioidanalgesicrems.com/RpcUI/products.u>



# FENTANYL AND FENTANYL ANALOGUES



OD deaths from fentanyl and fentanyl analogues, such as carfentanil, have increased 540% in three years.

Street fentanyl is illegally manufactured; it is generally NOT a diverted pharmaceutical product.

Two causes of fentanyl OD death: opioid-induced **respiratory depression** and **rigid chest wall syndrome**; higher or repeated doses of naloxone are required to reverse a fentanyl overdose.

Fentanyl is also found in heroin, cocaine, and methamphetamine.

# RISKS VERSUS BENEFITS

## RISKS

- Misuse, diversion, and addiction
- Abuse by patient or household contacts
- Interactions with other meds and substances
- Risk of neonatal abstinence syndrome
- Inadvertent exposure/ingestion by household contacts, especially children
- Life-threatening respiratory depression
- Overdose, especially as ER/LA formulations contain more MME than IR

## BENEFITS

- Analgesia
  - Reliable pain control
  - Quick analgesia (particularly with IRs)
- Continuous, predictable (with ER/LAs)
- Improved function
- Improved quality of life

SOURCE: Nicholson, B. Pain Pract. 2009;9(1):71-81. <http://onlinelibrary.wiley.com/doi/10.1111/j.1533-2500.2008.00232.x/abstract>



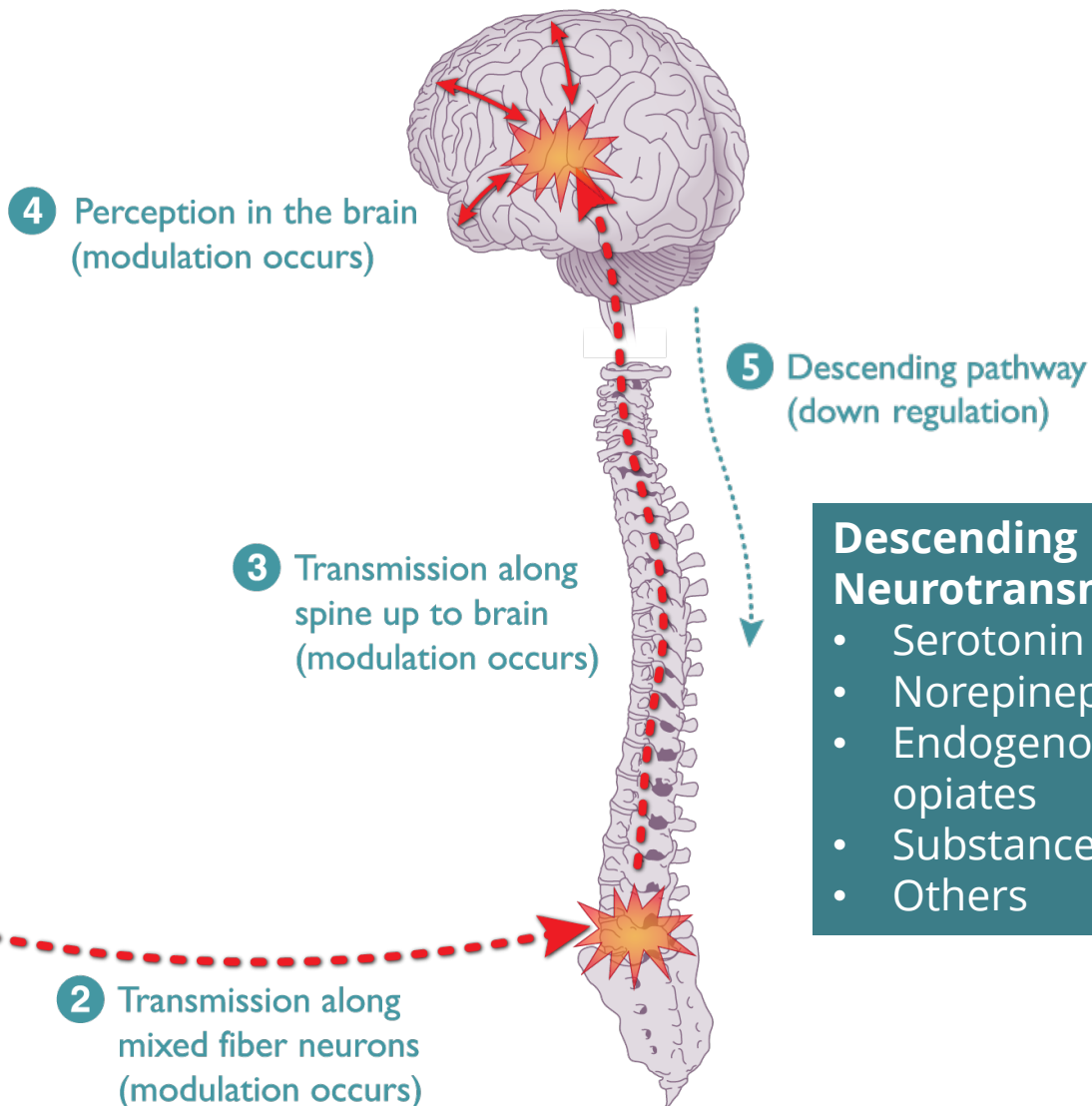
# CHAPTER 1

# PAIN

# THE NEUROMECHANISMS OF PAIN

## Peripheral Pain Modulators:

- Serotonin
- Histamines
- Prostaglandins
- Cytokines
- Bradykinin
- Substance P
- Others



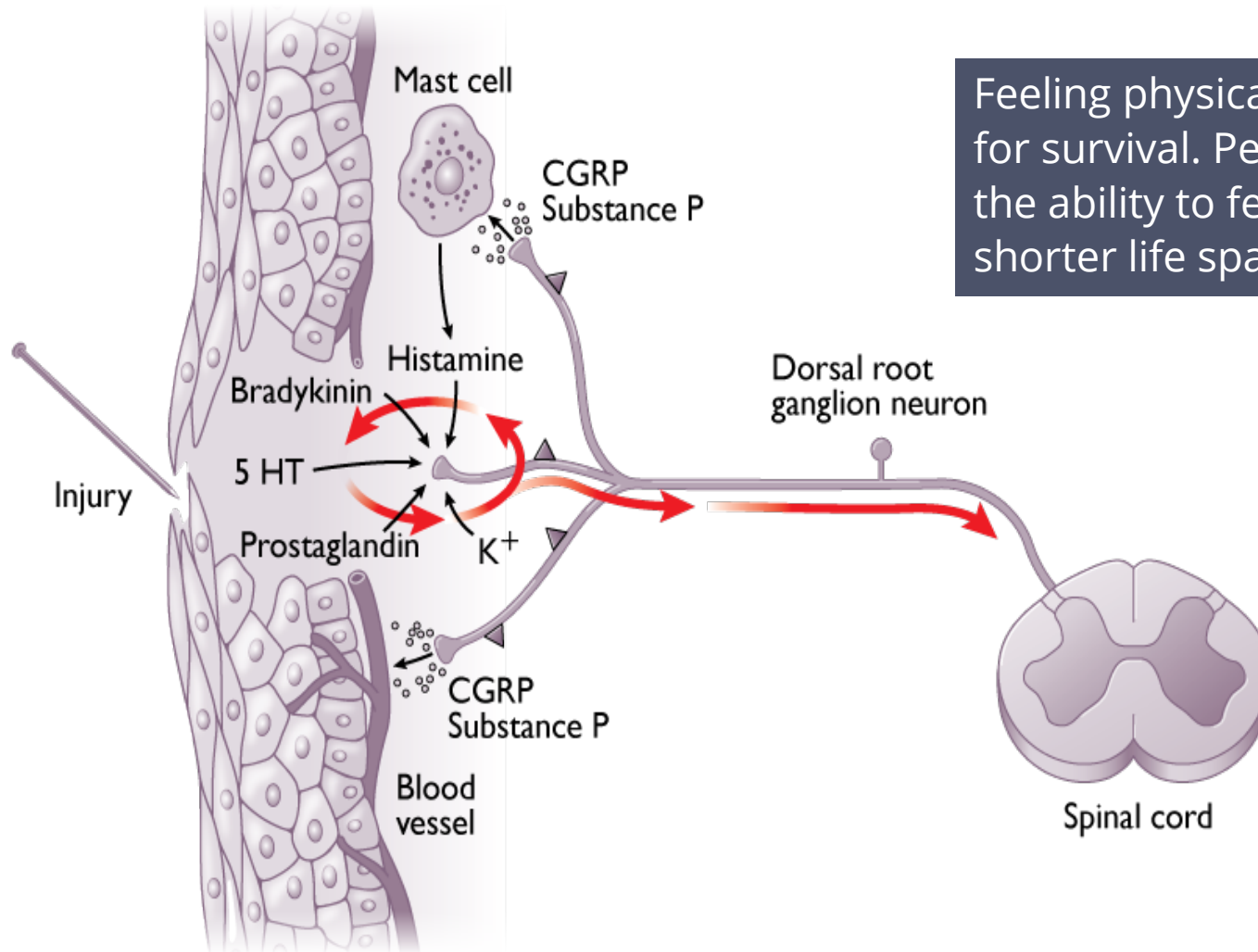
## Descending Neurotransmitters:

- Serotonin
- Norepinephrine
- Endogenous opiates
- Substance P
- Others



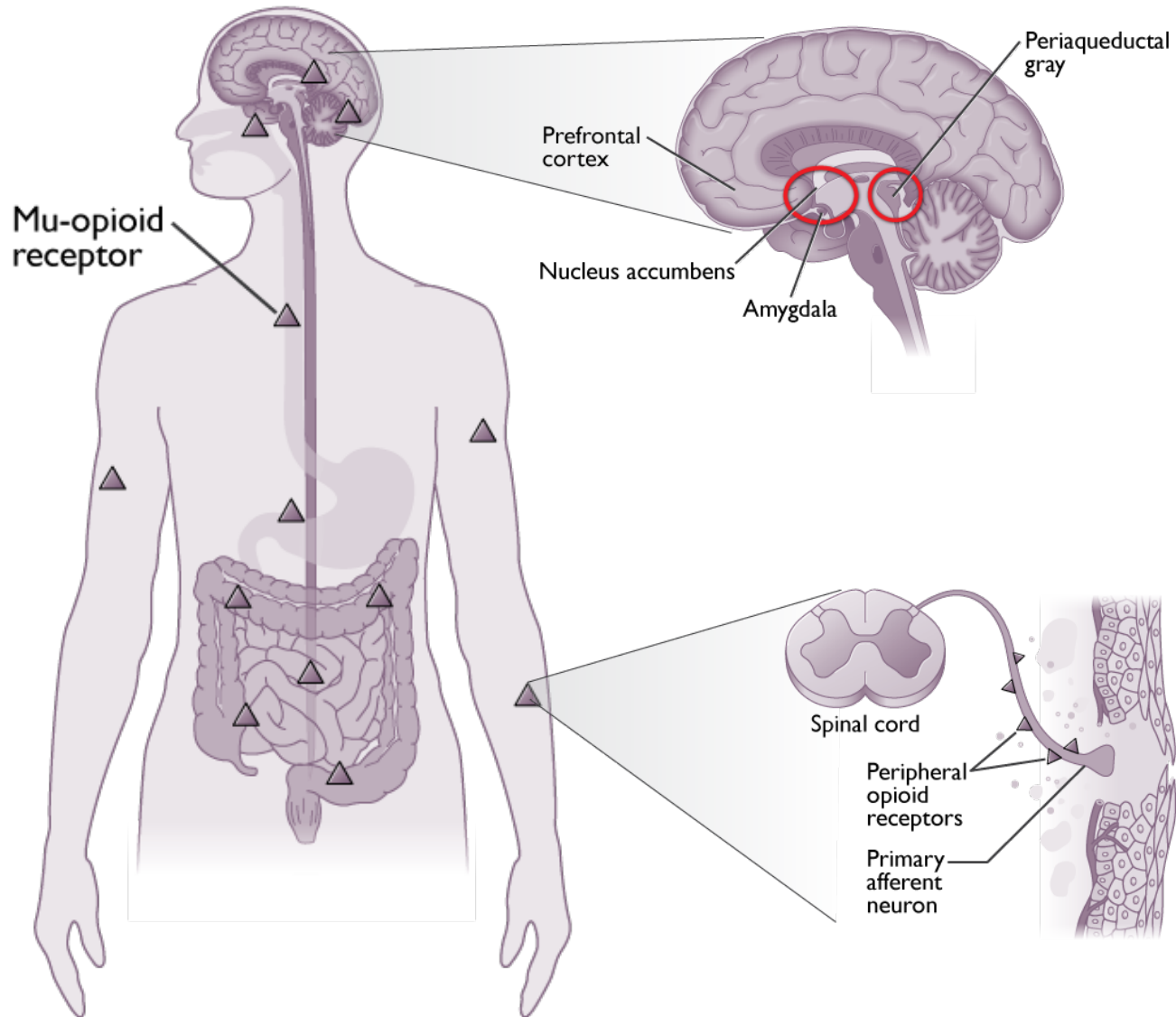
# MEDIATORS OF PERIPHERAL NOCICEPTION

Feeling physical pain is vital for survival. People who lose the ability to feel pain, have shorter life spans.

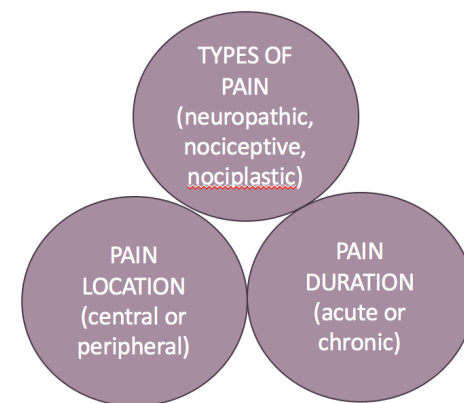
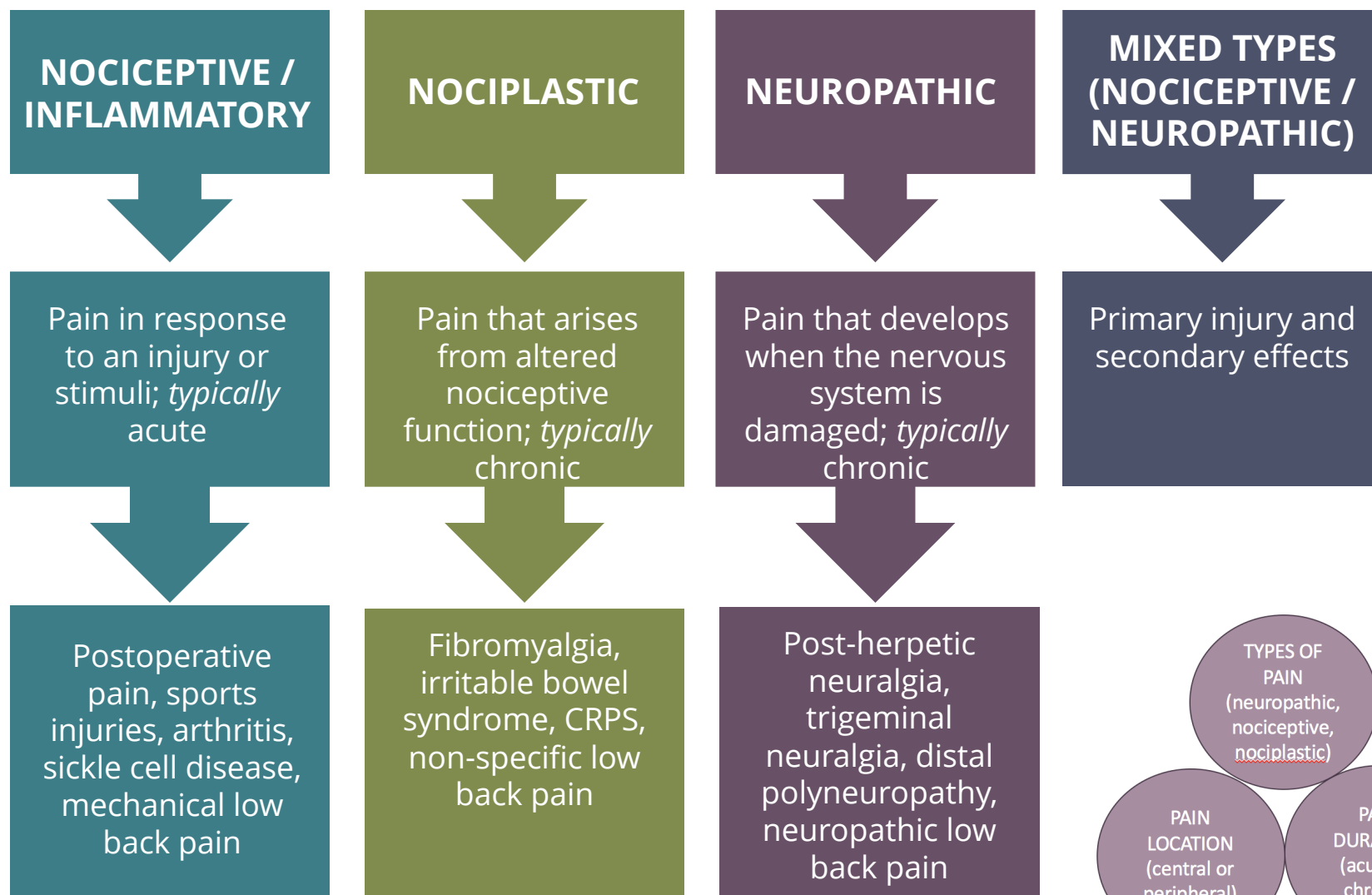


With thanks to Allan Basbaum and David Julius, University of California, San Francisco

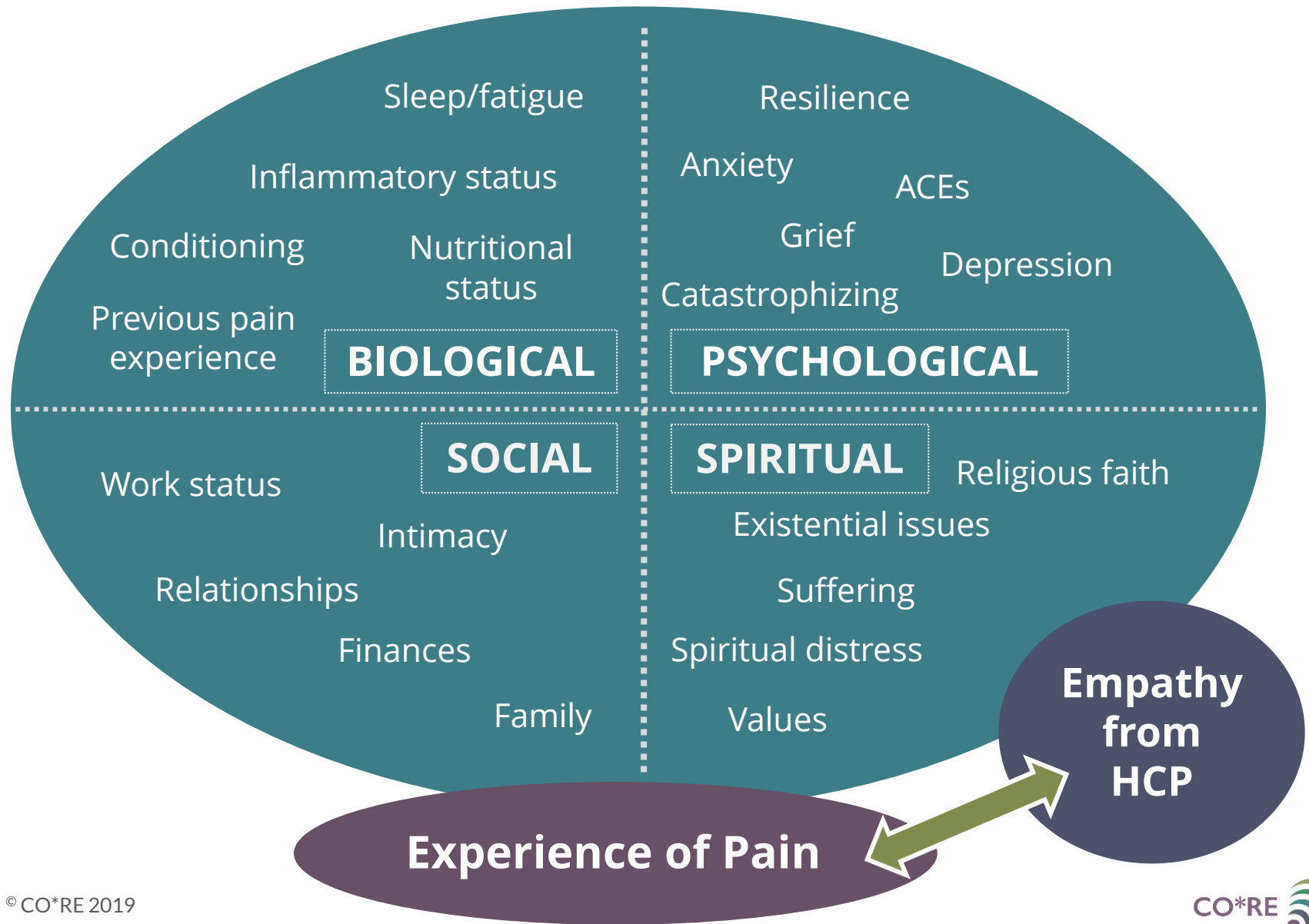
# OPIOID RECEPTOR LOCATIONS



# TYPES OF PAIN



# THE BIOPSYCHOSOCIAL SPIRITUAL CONTEXT OF PAIN





# PAIN CATASTROPHIZING

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

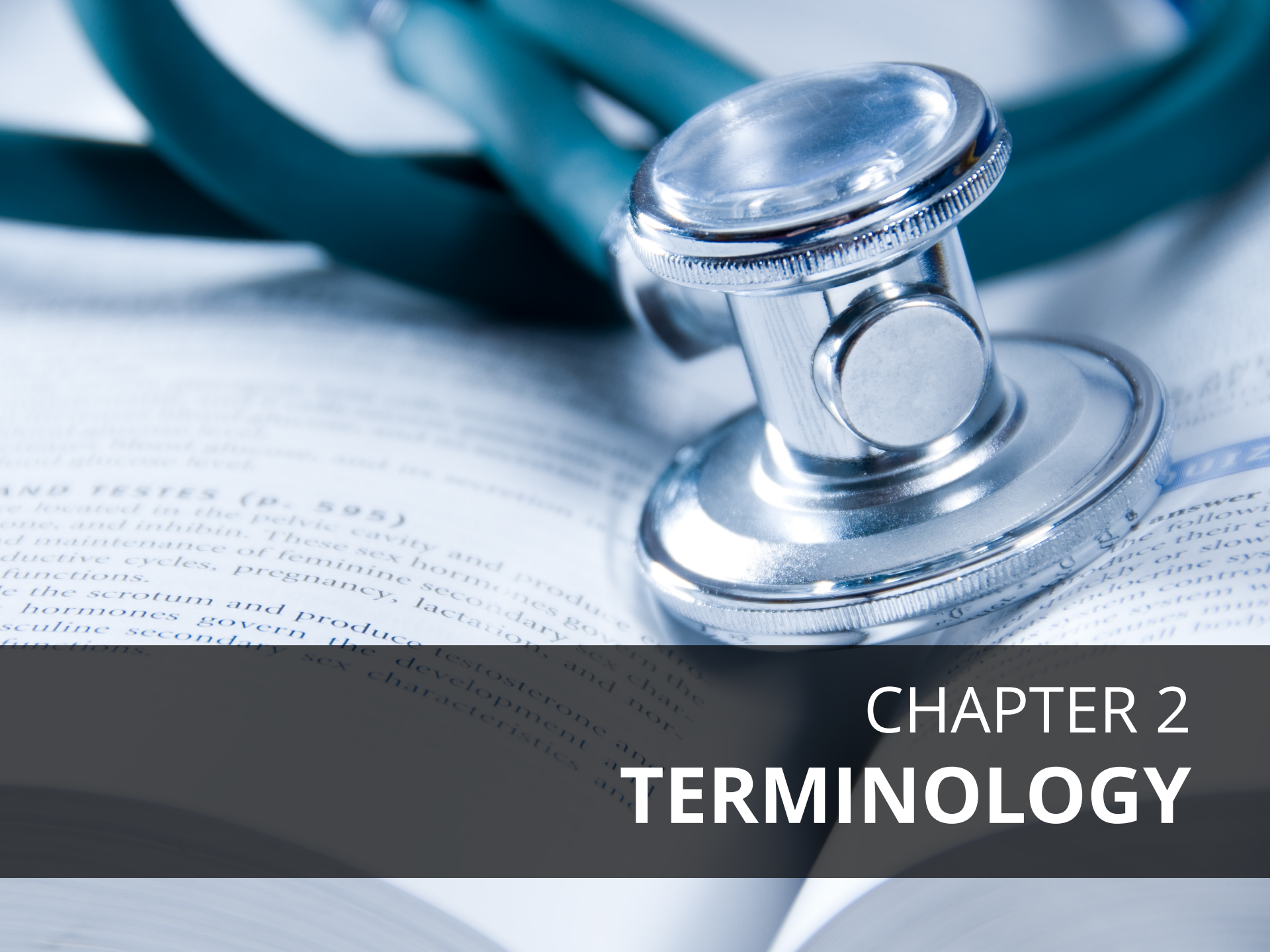
SOURCE: Pain Catastrophizing Scale © 2009 Dr. Michael JL Sullivan

- *"Tell me about your pain..."*
- Listen for rumination, feelings of hopelessness, or anticipation of negative outcomes.
- These feelings are important to identify because they can prolong and intensify pain; or lead to higher levels of suffering and altered perception of pain.
- If identified, shift to *"tell me about your life."*



HOW IS PAIN RESOLVED?





# CHAPTER 2 TERMINOLOGY

## WORDS MATTER: LANGUAGE CHOICE CAN REDUCE STIGMA

*“If you want to care for something, you call it a flower; if you want to kill something, you call it a weed.”*

—Don Coyhis

Commonly Used Term	Preferred Term
Addiction	Substance use disorder (SUD) [from the <i>DSM-5</i> <sup>®</sup> ]
Drug-seeking, aberrant/problematic behavior	Using medication not as prescribed
Addict	Person with substance use disorder (SUD)
Clean/dirty urine	Positive/negative urine drug screen

SOURCES: SAMHSHA Resource: <https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf>  
Scholten W. Public Health. 2017;153:147-153. DOI: [10.1016/j.puhe.2017.08.021](https://doi.org/10.1016/j.puhe.2017.08.021)

## WORDS MATTER: DEFINITIONS

<b>Misuse</b>	Use of a medication in a way other than the way it is prescribed
<b>Abuse</b>	Use of a substance with the intent of getting high
<b>Tolerance</b>	Increased dosage needed to produce a specific effect
<b>Dependence</b>	State in which an organism only functions normally in the presence of a substance
<b>Diversion</b>	Transfer of a legally controlled substance, prescribed to one person, to another person for illicit (forbidden by law) use
<b>Withdrawal</b>	Occurrence of uncomfortable symptoms or physiological changes caused by an abrupt discontinuation or dosage decrease of a pharmacologic agent
<b>MME</b>	Morphine milligram equivalents; a standard opioid dose value based on morphine and its potency; allows for ease of comparison and risk evaluations
<b>Chronic non-cancer pain (CNCP):</b>	Any painful condition that persists for $\geq 3$ months, or past the time of normal tissue healing, that is not associated with a cancer diagnosis

SOURCES: SAMHSA Resource: <https://www.samhsa.gov/capt/sites/default/files/resources/sud-stigma-tool.pdf>  
 World Health Organization, Ensuring Balance in National Policies on Controlled Substances.  
[https://www.who.int/medicines/areas/quality\\_safety/GLs\\_Ens\\_Balance\\_NOCP\\_Col\\_EN\\_sanend.pdf](https://www.who.int/medicines/areas/quality_safety/GLs_Ens_Balance_NOCP_Col_EN_sanend.pdf)





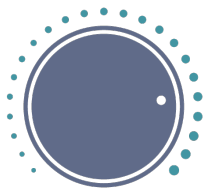
CHAPTER 3  
**ASSESSMENT**

# PAIN ASSESSMENT

## DESCRIPTION OF PAIN



Location



Intensity



Quality



Onset/  
duration



Variations/  
patterns/rhythms

WHAT RELIEVES THE PAIN?

WHAT CAUSES OR INCREASES THE PAIN?

EFFECTS OF PAIN ON PHYSICAL, EMOTIONAL, AND PSYCHOSOCIAL FUNCTION

PATIENT'S CURRENT LEVEL OF PAIN AND FUNCTION

SOURCES: Heapy A, Kerns RD. Psychological and behavioral assessment. In: Raj's Practical Management of Pain. 4th ed. 2008:279-295; Zacharoff KL, et al. Managing Chronic Pain with Opioids in Primary Care. 2nd ed. Newton, MA: Inflexion, Inc.;2010.

# PAST MEDICAL AND TREATMENT HISTORY

NONPHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

RELEVANT ILLNESSES



## PAST AND CURRENT OPIOID USE

- Query your state's Prescription Drug Monitoring Program (**PDMP**) to confirm patient report
- Contact past providers and obtain prior medical records
- For opioids currently prescribed, note the opioid, dose, regimen, and duration
- Determine whether the patient is **opioid-tolerant**

GENERAL EFFECTIVENESS OF CURRENT PRESCRIPTIONS



# PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

PDMPs are state-run, electronic databases that track controlled substance prescriptions in a state.

## PDMP DATABASES

- Provide a full accounting of the controlled substance prescriptions filled by a patient
- Nearly all are available online 24/7
- Required in most states; know your state laws

## BENEFITS

- Identify potential drug misuse/abuse
- Discover existing prescriptions not reported by patient
- Opportunity to discuss with patient
- Determine if patient is using multiple prescribers/pharmacies
- Identify drugs that increase overdose risk when taken together

# OBTAIN A COMPLETE SOCIAL AND PSYCHOLOGICAL HISTORY

## SOCIAL HISTORY

Employment, cultural background, social network, relationship history, legal history, and other behavioral patterns

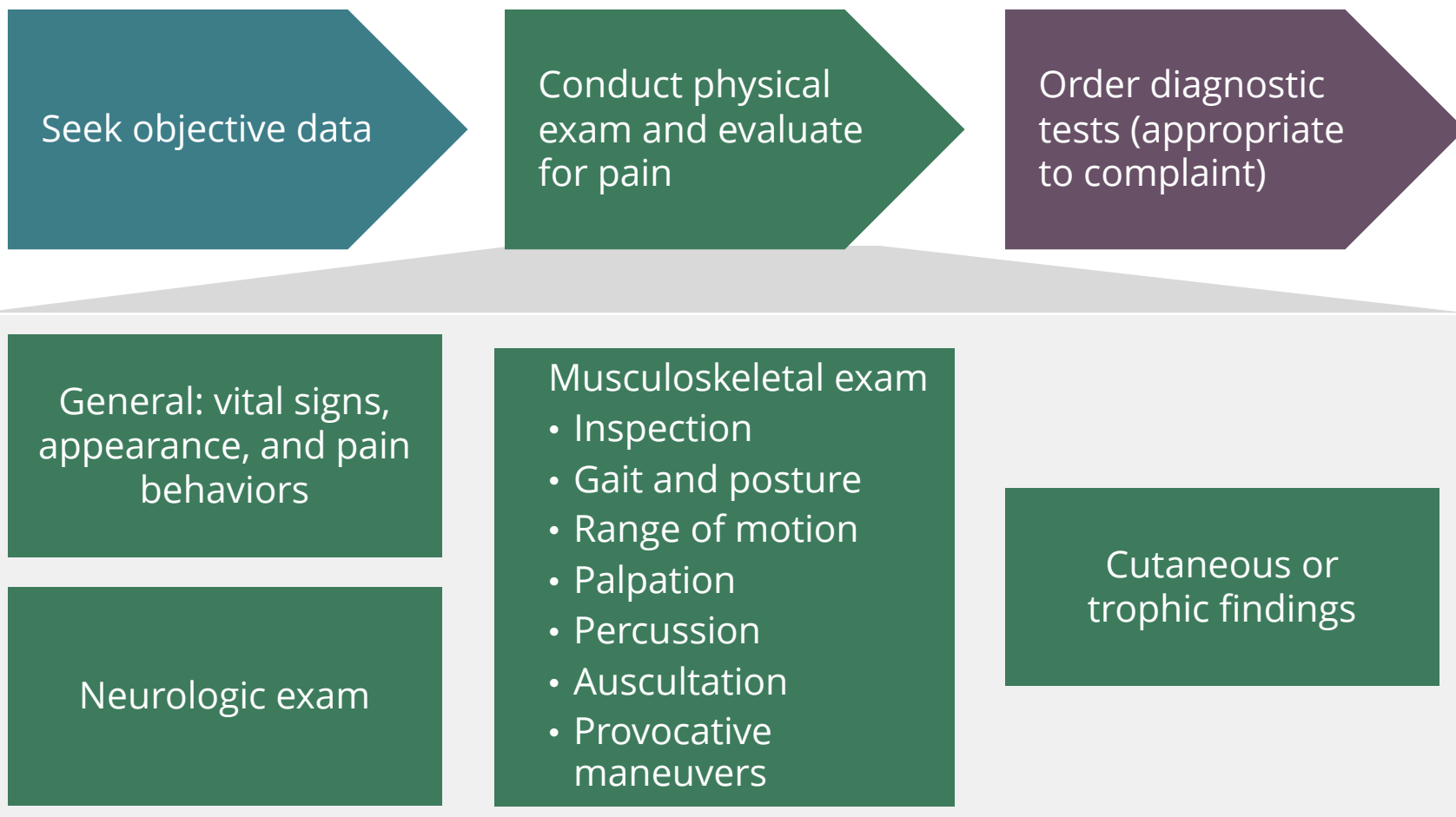
## PSYCHOLOGICAL HISTORY

Screen for:

- Mental health diagnoses, depression, anxiety, PTSD, current treatments
- Alcohol, tobacco, and recreational drug use
- History of adverse childhood experiences
- Family history of substance use disorder and psychiatric disorders



# PHYSICAL EXAM AND ASSESSMENT



SOURCES: Lalani I, Argoff CE. History and Physical Examination of the Pain Patient. In: Raj's Practical Management of Pain. 4th ed. 2008:177-188; Chou R, et al. J Pain. 2009;10:113-130.

# PAIN ASSESSMENT TOOL BOX

<http://core-rems.org/opioid-education/tools/>



## Pain Assessment Tools

**BPI or 5 A's**

## Functional Assessment

**SF-36, PPS, Geriatric Assessment**

## Pain intensity, Enjoyment of life, General activity

**PEG**

## Childhood Trauma Questionnaire

**ACE**

## Assessment in Advanced Dementia

**PAINAD**

1903 Date: [ ] / [ ] / [ ] (month) (day) (year) Study Name: \_\_\_\_\_  
Subject's initials: \_\_\_\_\_ Protocol #: \_\_\_\_\_  
Study Subject #: [ ] [ ] [ ] [ ] PI: \_\_\_\_\_  
Revision: 07/01/05

PLEASE USE BLACK INK PEN

### Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?  
 Yes  No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

Front Back  
Right Left Left Right

3. Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.  
 0  1  2  3  4  5  6  7  8  9  10  
No Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its **least** in the last 24 hours.  
 0  1  2  3  4  5  6  7  8  9  10  
No Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the **average**.  
 0  1  2  3  4  5  6  7  8  9  10  
No Pain As Bad As You Can Imagine

**Brief Pain Inventory**

## Psychological Measurement Tools (PHQ-9, GAD-7, etc.)





CHAPTER 4  
**CREATING THE PAIN  
TREATMENT PLAN**

# COMPONENTS OF A MULTIMODAL TREATMENT PLAN FOR PAIN

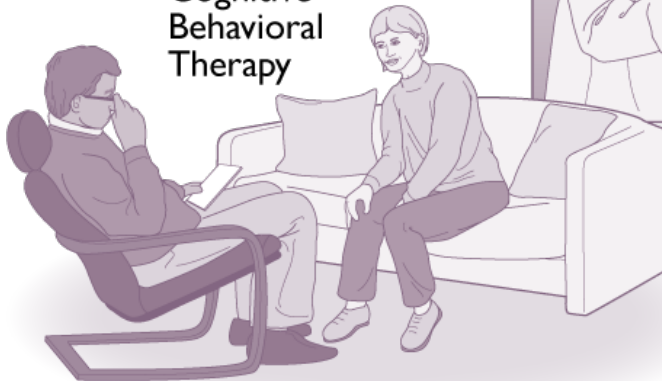
All Staff Working  
as a Treatment Team



Physical &  
Occupational  
Therapy

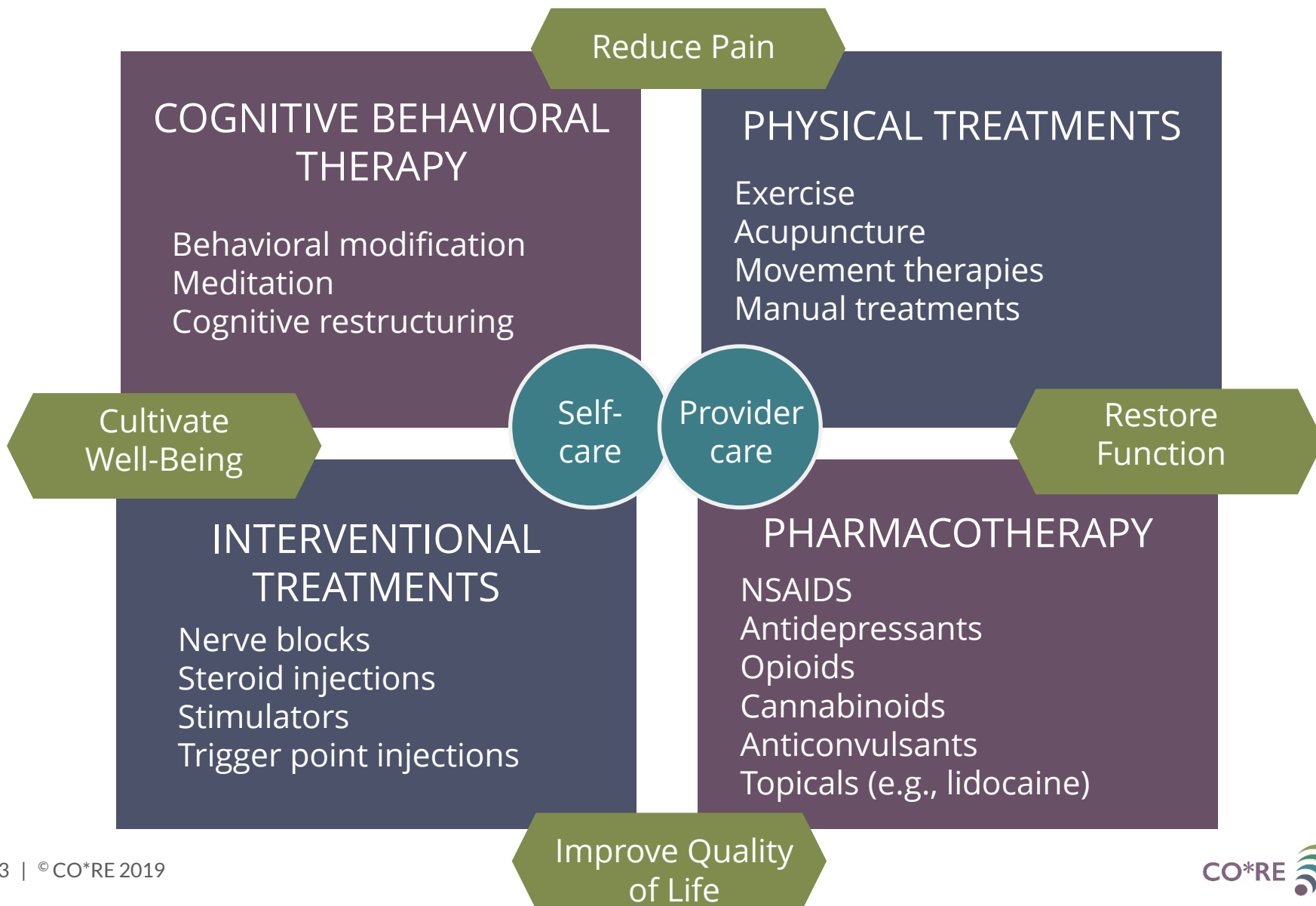


Cognitive  
Behavioral  
Therapy



Pharmacotherapy

# PAIN MANAGEMENT GOALS AND TREATMENT OPTIONS: A MULTIMODAL APPROACH





# EVIDENCE-BASED NONPHARMACOLOGIC TREATMENTS

What is appropriate  
for your patient?

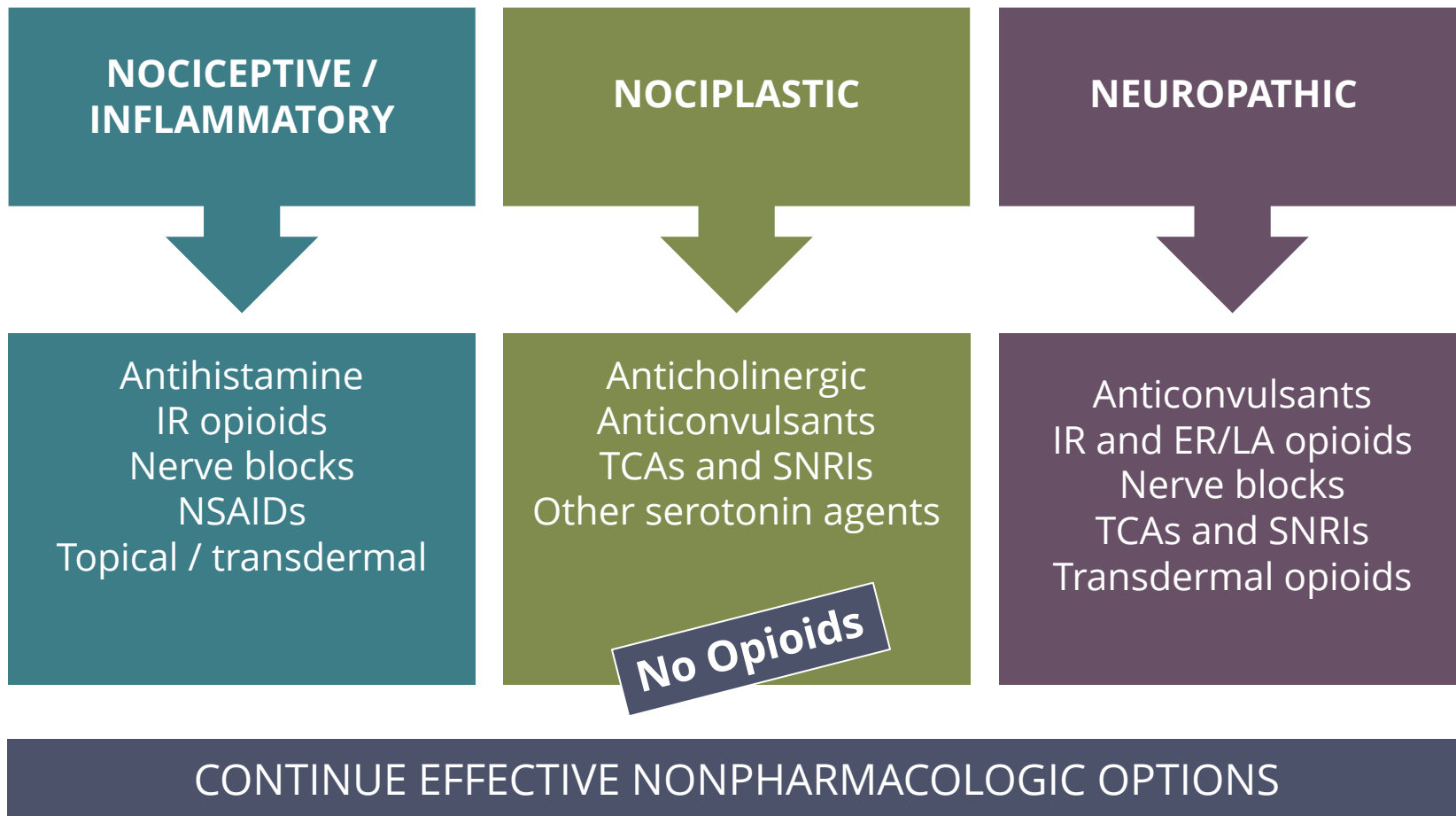


- Tai Chi
- Yoga
- CBT and ACT
- Acupuncture
- PT/OT/aquatic
- Mindfulness meditation
- OMT
- Massage therapy
- Chiropractic
- Neuromodulation or surgical approaches (in some situations)

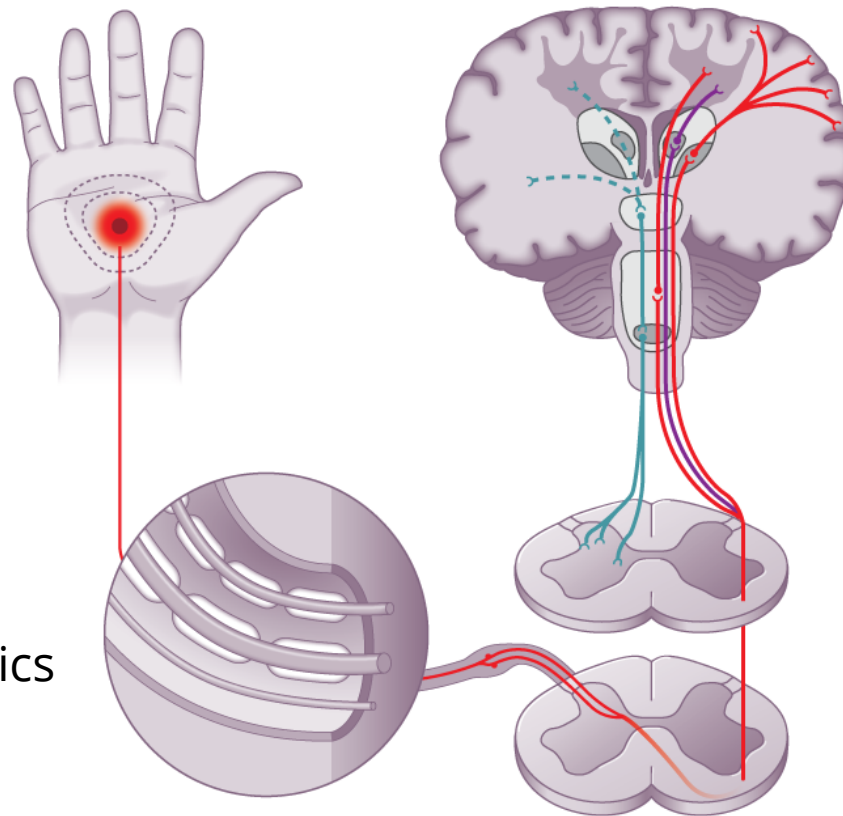
CBT = cognitive behavioral therapy; ACT = acceptance commitment therapy; OMT = osteopathic manipulative therapy



# PHARMACOLOGIC TREATMENTS BY TYPE OF PAIN



# APPROPRIATE MEDICATIONS FOR PERIPHERALLY MEDIATED VERSUS CENTRALLY MEDIATED PAIN



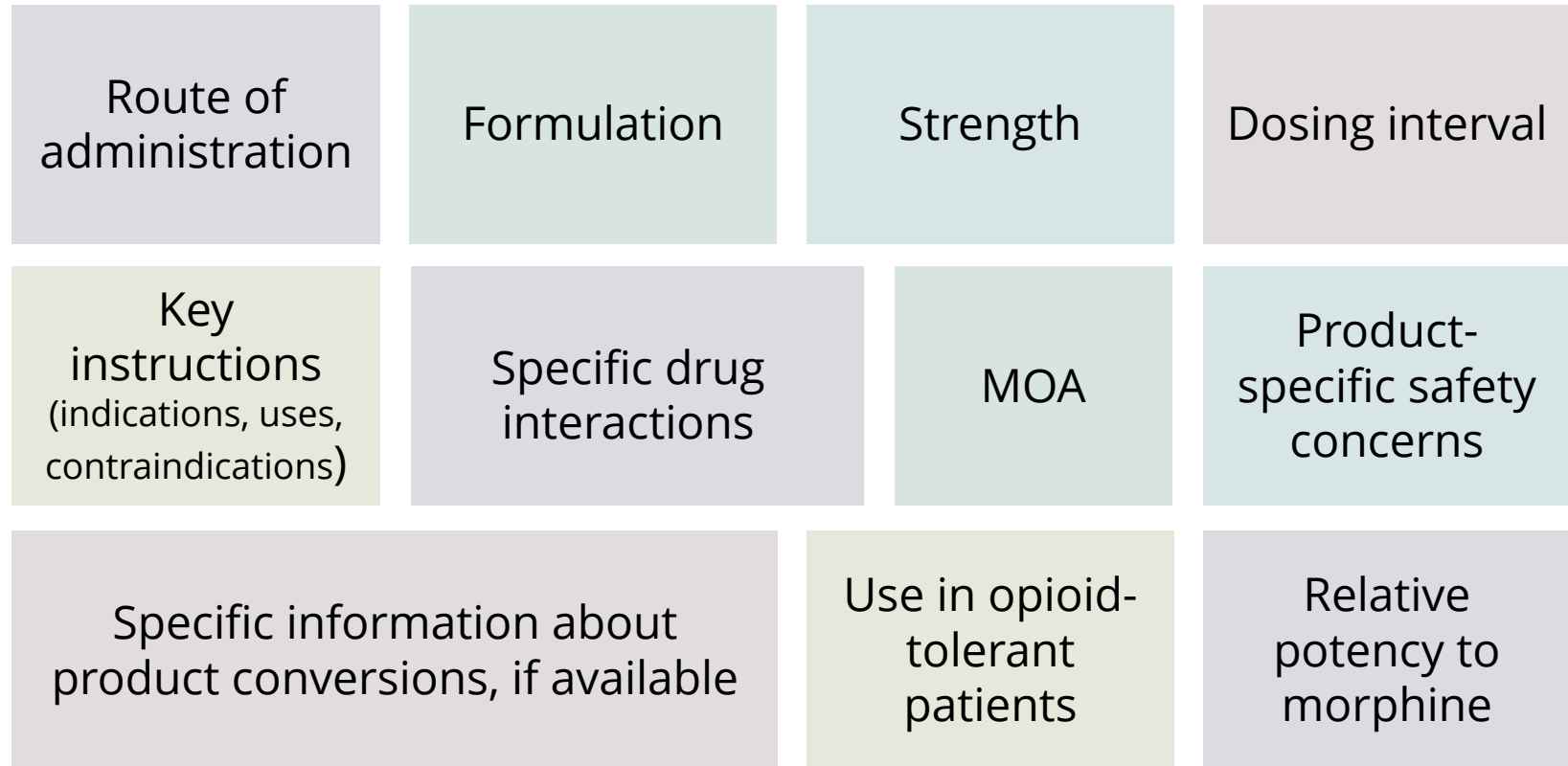
## Peripherally Mediated Pain:

- Acetaminophen
- Antihistamines
- NSAIDs
- Opioids
- Topical anesthetics

## Centrally Mediated Pain:

- Alpha-2 agonists
- Anticonvulsants
- Ca<sup>+</sup> channel antagonists
- NMDA
- Opioids
- TCA/SNRI antidepressants

# DRUG CHARACTERISTICS TO CONSIDER BEFORE PRESCRIBING



Opioid product information available at  
<https://opioidanalgesicrems.com/RpcUI/products.u>

## CONSIDER AN OPIOID ONLY WHEN:

Potential benefits are likely to outweigh risks

Patient has failed to adequately respond to non-opioid and nonpharmacological interventions

Patient has neuropathic or nociceptive pain that is moderate to severe



SOURCES: Chou R, et al. J Pain. 2009;10:113-130. Department of Veterans Affairs, Department of Defense. VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. 2010.

# OPIOID MISUSE RISK ASSESSMENT TOOLS

<http://core-remis.org/opioid-education/tools/>



## TOOLS FOR PATIENTS CONSIDERED FOR OPIOID THERAPY

**ORT-OD** Opioid Risk Tool

**SOAPP**<sup>®</sup> Screener and Opioid Assessment for Patients with Pain

**DIRE** Diagnosis, Intractability, Risk, and Efficacy score

## TOOLS FOR SUBSTANCE USE DISORDER

**CAGE-AID** Cut down, Annoyed, Guilty, Eye-Opener tool, Adapted to Include Drugs

**RAFFT** Relax, Alone, Friends, Family, Trouble

**DAST** Drug Abuse Screening Test

**CTQ** Childhood Trauma Questionnaire

**ACEs** Adverse Childhood Experiences

**Also for patients  
with chronic pain:**

- Get a baseline UDT
- Check the PDMP

# A CLOSER LOOK AT THE ORT-OUT

## Opioid Risk Tool – OUD (ORT-OUT)

This tool should be administered to patients upon an initial visit prior to beginning or continuing opioid therapy for pain management. A score of 2 or lower indicates low risk for future opioid use disorder; a score of  $\geq 3$  indicates high risk for opioid use disorder.

Mark each box that applies	YES	NO
<b>Family history of substance abuse</b>		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
<b>Personal history of substance abuse</b>		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16-45 years	1	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
<b>Scoring totals</b>		

Substance use disorder history does not prohibit treatment with opioids, but may require additional monitoring and expert consultation or referral.

### Scoring:

- $\leq 2$ : low risk
- $\geq 3$ : high risk

SOURCE: Cheatle, M., et al. JPain 2019; Jan 26.

# OPIOID SIDE EFFECTS AND ADVERSE EVENTS



SIDE EFFECTS	ADVERSE EVENTS
Respiratory depression	Falls or fractures
Opioid-induced constipation (OIC)	Addiction
Myoclonus (twitching or jerking)	Overdose
Sedation, cognitive impairment	Hospitalization
Sweating, miosis, urinary retention	Disability or permanent damage
Allergic reactions	Death
Hypogonadism	
Tolerance, physical dependence, hyperalgesia	

Prescribers should report serious AEs and medication errors to the FDA:  
<https://www.fda.gov/media/76299/download>  
or 1-800-FDA-1088



# OPIOID-INDUCED RESPIRATORY DEPRESSION

## MORE LIKELY TO OCCUR:

- In elderly, cachectic, or debilitated patients
- If given concomitantly with other drugs that depress respiration
- In patients who are opioid-naïve or have just had a dose increase
- Opioids are **contraindicated** in patients with respiratory depression or conditions that increase risk

## HOW TO REDUCE RISK:

- Ensure proper dosing and titration
- **Do not overestimate** dose when converting dosage from another opioid product
  - Can result in fatal overdose with first dose
- Instruct patients to swallow tablets/capsules whole
  - Dose from cut, crushed, dissolved, or chewed tablets/capsules may be fatal, particularly in opioid-naïve individuals

# TRANSDERMAL/TRANSMUCOSAL DOSAGE FORMS



Do not cut, damage, chew, or swallow

Prepare skin: clip (not shave) hair and wash area with water

Rotate location of application

Do not apply buccal film products if film is cut, damaged, or changed in any way -- use the entire film

Note that metal foil backings are not safe for use in MRIs

Monitor patients with fever for signs or symptoms of increased opioid exposure

Note that exertion or exposure to external heat can lead to fatal overdose

## FOR SAFER USE: KNOW DRUG INTERACTIONS, PK, AND PD

CNS depressants can potentiate sedation and respiratory depression

Some ER/LA products rapidly release opioid (dose dump) when exposed to alcohol  
Some drug levels may increase without dose dumping

Opioid use with MAOIs may increase respiratory depression

Certain opioids with MAOIs can cause serotonin syndrome

Opioid use can reduce efficacy of diuretics

Inducing release of antidiuretic hormone

Many opioids can prolong QTc interval, check the PI; methadone requires extra caution

Drugs that inhibit or induce CYP enzymes can increase or lower blood levels of some opioids

# OPIOIDS AND CYP450 ENZYME INTERACTIONS

Metabolism of several commonly used opioids occurs through the cytochrome P450 system

Be aware of potential inhibitors (e.g., macrolides, azole antifungals) and inducers (e.g., carbamazepine)

Genetic and phenotypic variations in patient response to certain opioids

Refer to product-specific information in the drug package insert before prescribing

SOURCE: <https://dailymed.nlm.nih.gov/dailymed/index.cfm>

# DRUG INTERACTIONS COMMON TO OPIOIDS

## Other CNS Depressants

- Concurrent use can increase risk of respiratory depression, hypotension, profound sedation, or coma
- Reduce initial dose of one or both agents

## Partial Agonists\* or Mixed Agonist/Antagonists †

- Avoid concurrent use with full opioid agonist
- May reduce analgesic effect and/or precipitate withdrawal

## Skeletal Muscle Relaxants

- Concurrent use may enhance neuromuscular blocking action and increase respiratory depression

## Anticholinergic Medication

- Concurrent use increases risk of urinary retention and severe constipation
- May lead to paralytic ileus

\*Buprenorphine †pentazocine, nalbuphine, butorphanol





# SPECIAL POPULATIONS

# OLDER ADULTS

## RISK FOR RESPIRATORY DEPRESSION

- Age-related changes in distribution, metabolism, excretion; absorption less affected

## ACTIONS

- Monitor
  - Initiation and titration
  - Concomitant medications (polypharmacy)
  - Falls risk, cognitive change, psychosocial status
- Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients
- Start low, go slow, but GO
- Routinely initiate a bowel regimen
- Patient and caregiver reliability/risk of diversion



SOURCE: American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons. J Am Geriatr Soc. 2009;57:1331-46. Chou R, et al. J Pain. 2009;10:113-30.

# WOMEN OF CHILDBEARING POTENTIAL

Neonatal opioid withdrawal syndrome is a potential risk of opioid therapy

## GIVEN THIS POTENTIAL RISK, CLINICIANS SHOULD:

- Discuss family planning, contraceptives, breast feeding plans with patients
  - Counsel women of childbearing potential about risks and benefits of opioid therapy during pregnancy and after delivery
  - Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks to fetus
  - Refer to a high-risk OB/Gyn who will ensure appropriate treatment for the baby
- Perform universal screening to avoid neonatal abstinence syndrome
- For women using opioids on a daily basis, consider methadone or buprenorphine



SOURCES: Chou R, et al. J Pain. 2009;10:113-30; ACOG Committee on Obstetric Practice, August 2017

# CHILDREN AND ADOLESCENTS

HANDLE WITH CARE: JUDICIOUS & LOW-DOSE  
USE OF IR FOR BRIEF THERAPY

THE SAFETY AND EFFECTIVENESS OF MOST  
OPIOIDS ARE UNESTABLISHED

- Pediatric analgesic trials pose challenges
- Transdermal fentanyl approved in children  $\geq 2$
- Oxycodone ER dosing changes for children  $\geq 11$

ER/LA OPIOID INDICATIONS ARE PRIMARILY  
LIFE-LIMITING CONDITIONS

WHEN PRESCRIBING ER/LA OPIOIDS TO CHILDREN:

- Consult pediatric palliative care team or pediatric pain specialist or refer to a specialized multidisciplinary pain clinic



SOURCES: Berde CB, et al. *Pediatrics*. 2012;129:354-364; Gregoire MC, et al. *Pain Res Manag* 2013;18:47-50; Mc Donnell C. *Pain Res Manag*. 2011;16:93-98; Slater ME, et al. *Pain Med*. 2010;11:207-14.



# OTHER POPULATIONS NEEDING SPECIAL TREATMENT CONSIDERATIONS

- Persons with sleep disorders or sleep-disordered breathing (sleep apnea)
- Persons with dementia/ nonverbal patients
- Persons with obesity
- Persons with renal/ hepatic impairment
- Persons with psychiatric disorders
- Persons at end-of-life
- Persons with substance use disorder



# WHEN TO CONSIDER A TRIAL OF AN OPIOID

## ADD YOUR CASE STUDY TITLE HERE

- Add your case study data points here
- And here
- And here

## ADD YOUR CASE STUDY TITLE HERE

- Add your case study data points here
- And here
- And here



# INFORMED CONSENT

When initiating a pain treatment plan, confirm patient understanding of informed consent to establish:

ANALGESIC AND FUNCTIONAL GOALS OF TREATMENT

EXPECTATIONS

POTENTIAL RISKS

ALTERNATIVES

PATIENT'S UNDERSTANDING

PATIENT'S DECISION

# PATIENT PROVIDER AGREEMENT (PPA)

## REINFORCE EXPECTATIONS FOR APPROPRIATE AND SAFE OPIOID USE

- Clarify treatment plans and goals
  - One prescriber
  - Consider one pharmacy
  - Safeguards
    - Do not store in medicine cabinet
    - Keep locked (medication safe)
    - Do not share or sell
  - Instructions for disposal when no longer needed
  - Prescriber notification for any event resulting in a pain medication prescription
- Follow-up plan
  - Monitoring
    - Random UDT and pill counts
  - Refill procedure
  - Identify behaviors indicating need for discontinuation
  - Exit strategy
  - Signed by both

# PPA NONADHERENCE

Behavior outside the boundaries of agreed-on treatment plan

Unsanctioned dose escalations or other noncompliance with therapy on 1 or 2 occasions

Unapproved use of the drug to treat another symptom

Openly acquiring similar drugs from other medical sources

Multiple dose escalations or other noncompliance with therapy despite warnings

Prescription forgery

Obtaining prescription drugs from nonmedical sources

Any of these behaviors merits investigation:  
proceed with caution



CHAPTER 5  
**MANAGING PATIENTS ON  
OPIOID ANALGESICS**

# INITIATING OPIOIDS

- Begin with IR
- Prescribe the lowest effective dosage
- Use caution at any dosage, but particularly when:
  - Increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day
  - Carefully justify a decision to titrate dosage to  $\geq 90$  MME/day
- Always include dosing instructions, including daily maximum
- Be aware of interindividual variability of response
- Co-prescribe naloxone (if indicated)
- Co-prescribe bowel regimen
- Re-evaluate risks/benefits within 1 – 4 weeks (could be as soon as 3 – 5 days) of initiation or dose escalation
- Re-evaluate risks/benefits every 3 months; if benefits do not outweigh harms, optimize other therapies and work to taper and discontinue

There are differences in benefit, risk and expected outcomes for patients with chronic pain and cancer pain, as well as for hospice and palliative care patients.

# ONGOING AND LONG-TERM MANAGEMENT OF PATIENTS ON OPIOID ANALGESICS

## PERIODIC REVIEW OF PAIN

- Is the patient making progress toward their functional goals?
- Reset goals if required or indicated; develop reasonable expectations
- Monitor for breakthrough pain
- Review adverse events/side effects at each visit
  - Evaluate bowel function
  - Screen for endocrine function as needed
  - Report adverse events to the FDA website
  - Implement opioid rotation, as indicated

Prescribers should report serious AEs and medication errors to the FDA:  
<https://www.fda.gov/media/76299/download>  
or 1-800-FDA-1088



# ONGOING AND LONG-TERM MANAGEMENT OF PATIENTS ON OPIOID ANALGESICS

## MONITORING FOR SAFETY

- Check PDMP (when clinically indicated or legally mandated)
- Use urine drug testing (UDT)
- Reassess risk of SUD and/or OUD
- Monitor adherence to the treatment plan
  - Medication reconciliation
  - Evaluate for nonadherence

## DISCONTINUING AND TAPERING

- When is opioid therapy no longer necessary?

# MONITORING PAIN AND SUBSTANCE USE DISORDER

## PAIN – 5 A's

- **A**nalgesia
- **A**ctivity/Function
- **A** aberrant/problematic behavior, not present
- **A**dverse events
- **A**ffect

## SUD – 5 C's

- **C**ontrol, loss of
- **C**ompulsive use
- **C**raving drug
- **C**ontinued use
- **C**hronic problem

# WHEN TO MOVE FROM IR TO ER/LA OPIOIDS

## PRIMARY REASONS

- Maintain stable blood levels (steady state plasma)
- Longer duration of action
- Multiple IR doses needed to achieve effective analgesia
- Poor analgesic efficacy despite dose titration
- Less sleep disruption

## OTHER POTENTIAL REASONS

- Patient desire or need to try a new formulation
- Cost or insurance issues
- Adherence issues
- Change in clinical status requiring an opioid with different pharmacokinetics
- Problematic drug-drug interactions



# CONSIDERATIONS FOR CHANGE FROM IR TO ER/LA OPIOIDS

## DRUG AND DOSE SELECTION IS CRITICAL

Some ER/LA opioids or dosage forms are only recommended for opioid-tolerant patients

- ANY strength of transdermal fentanyl or hydromorphone ER
- Certain strengths/ doses of other ER/LA products (check drug prescribing information)

## MONITOR PATIENTS CLOSELY FOR RESPIRATORY DEPRESSION

- Especially within 24 – 72 hours of initiating therapy and increasing dosage

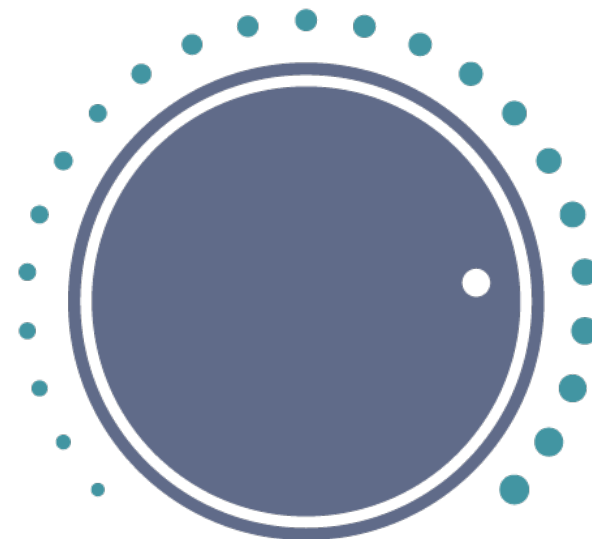
## INDIVIDUALIZE DOSAGE BY TITRATION BASED ON EFFICACY, TOLERABILITY, AND PRESENCE OF AEs

- Check ER/LA opioid product PI for minimum titration intervals
- Supplement with IR analgesics (opioid and non-opioid) if pain is not controlled during titration

SOURCES: Chou R, et al. J Pain. 2009;10:113-130; FDA. Education Blueprint Healthcare Providers Involved in the Treatment and Monitoring of Patients with Pain 09/2018, [https://www.accessdata.fda.gov/drugsatfda\\_docs/rems/Opioid\\_analgesic\\_2018\\_09\\_18\\_FDA\\_Blueprint.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_analgesic_2018_09_18_FDA_Blueprint.pdf)

## OPIOID-INDUCED HYPERALGESIA

- An increased sensitivity to pain
- Consider this explanation if:
  - Pain increases despite dose increases
  - Pain appears in new locations
  - Patient becomes more sensitive to painful stimuli
  - Patient is not improving in the absence of underlying cause progression
- Usually occurs at high MME dosages and over long periods of time
- A physiological phenomenon that can happen to anyone



SOURCE: Yi P, Pryzbylkowski P. Opioid induced hyperalgesia. Pain Medicine 2015; 16: S32-S36

# OPIOID TOLERANCE

If opioid tolerant, still use caution at higher doses

**Patients considered opioid tolerant are taking at least**

- 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hour
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- An equianalgesic dose of another opioid

**IMPORTANT**

FOR 1 WEEK  
OR LONGER



**Also use caution when rotating a patient on an IR opioid to a different ER/LA opioid**

Products restricted to opioid tolerant individuals include transdermal fentanyl (Duragesic) and hydromorphone (Exalgo).

SOURCE: The Opioid Analgesics Risk Evaluation & Mitigation Strategy product search  
<https://opioidanalgesicrems.com/RpcUI/products.u>



# OPIOID TOLERANCE VERSUS PHYSICAL DEPENDENCE

## TOLERANCE

- Occurs when increased dose is needed to maintain the functional status no longer achieved by current dose
- CNS and respiratory depression can develop with dose increase



## PHYSICAL DEPENDENCE

- Occurs when an organism only functions normally in the presence of the substance
- Abrupt discontinuation or dosage decrease causes uncomfortable symptoms of withdrawal

Both **tolerance** and **physical dependence** are physiological adaptations to chronic opioid exposure and **DO NOT** equal addiction or opioid use disorder

# OPIOID ROTATION

## DEFINITION

A change from an existing opioid regimen to another opioid with the goal of improving therapeutic outcomes or to avoid AEs attributed to the existing drug



## RATIONALE

Used when differences in pharmacologic or other effects make it likely that a switch will improve outcomes

- Effectiveness and AEs of different mu-opioids vary among patients
- Patient tolerant to first opioid might have improved analgesia from second opioid at a dose lower than calculated from an Equianalgesic Dosing Table (EDT)

SOURCES: Fine PG, et al. J Pain Symptom Manage. 2009;38:418-425; Knotkova H, et al. J Pain Symptom Manage. 2009;38:426-439; Pasternak GW. Neuropharmacol. 2004;47(suppl 1):312-323.

# EQUIANALGESIC DOSING TABLES (EDT)

Many different versions:

Published

Online

Online interactive

Smart-phone apps



Vary in terms of:

Equianalgesic values

Whether ranges are used



**Which opioids are included:** May or may not include transdermal opioids, rapid-onset fentanyl, ER/LA opioids, or opioid agonist-antagonists



## EXAMPLE OF AN EDT FOR ADULTS

DRUG	EQUIANALGESIC DOSE		USUAL STARTING DOSE	
	SC/IV	PO	PARENTERAL	PO
<b>Morphine</b>	10 mg	30 mg	2.5 – 5 mg SC/IV q3 – 4hr (1.25 – 2.5 mg)	5 – 15 mg q3 – 4hr (IR or oral solution) (2.5 – 7.5 mg)
<b>Oxycodone</b>	NA	20 mg	NA	5 – 10 mg q3 – 4hr (2.5 mg)
<b>Hydrocodone</b>	NA	30 mg	NA	5 mg q3 – 4hr (2.5 mg)
<b>Hydromorphone</b>	1.5 mg	7.5 mg	0.2 – 0.6 mg SC/IV q2 – 3hr (0.2 mg)	1– 2 mg q3 – 4hr (0.5 – 1 mg)

# MU-OPIOID RECEPTORS AND INCOMPLETE CROSS TOLERANCE

MU-OPIOIDS BIND TO MU RECEPTORS

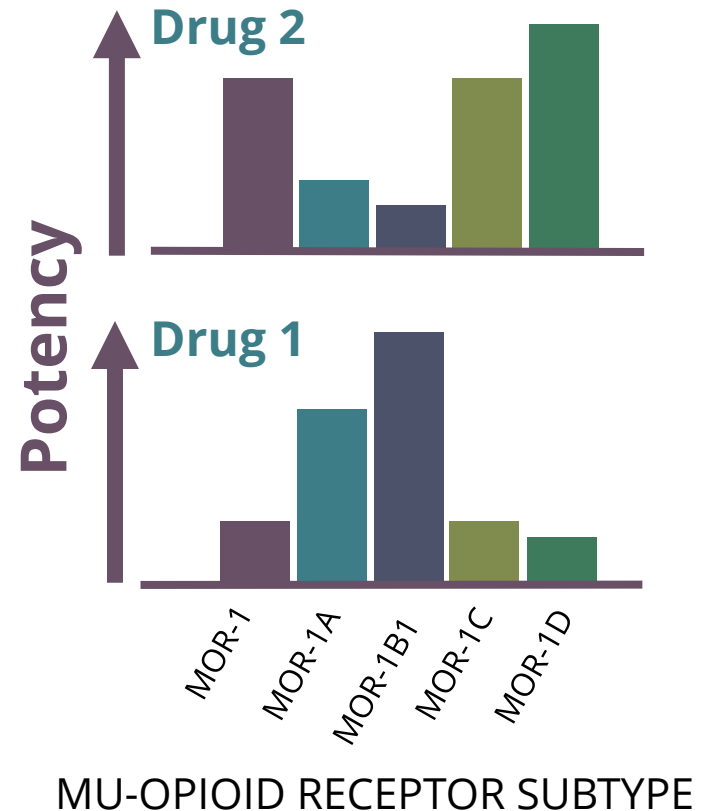
MANY MU RECEPTOR SUBTYPES

Mu-opioids produce **subtly different** pharmacologic responses based on distinct activation profiles of mu receptor subtypes

MAY HELP EXPLAIN:

Interpatient variability in response to mu-  
opioids

Incomplete cross tolerance among mu-  
opioids



# GUIDELINES FOR OPIOID ROTATION

Calculate equianalgesic dose of new opioid from EDT

REDUCE CALCULATED EQUIANALGESIC DOSE BY 25% – 50%\*

SELECT % REDUCTION BASED ON CLINICAL JUDGMENT

CLOSER TO 50% REDUCTION IF PATIENT

- Is receiving a relatively high dose of current opioid regimen
- Is elderly or medically frail

CLOSER TO 25% REDUCTION IF PATIENT

- Does not have these characteristics
- Is changing route of administration



\*75% – 90% reduction for methadone



## GUIDELINES FOR OPIOID ROTATION *(continued)*



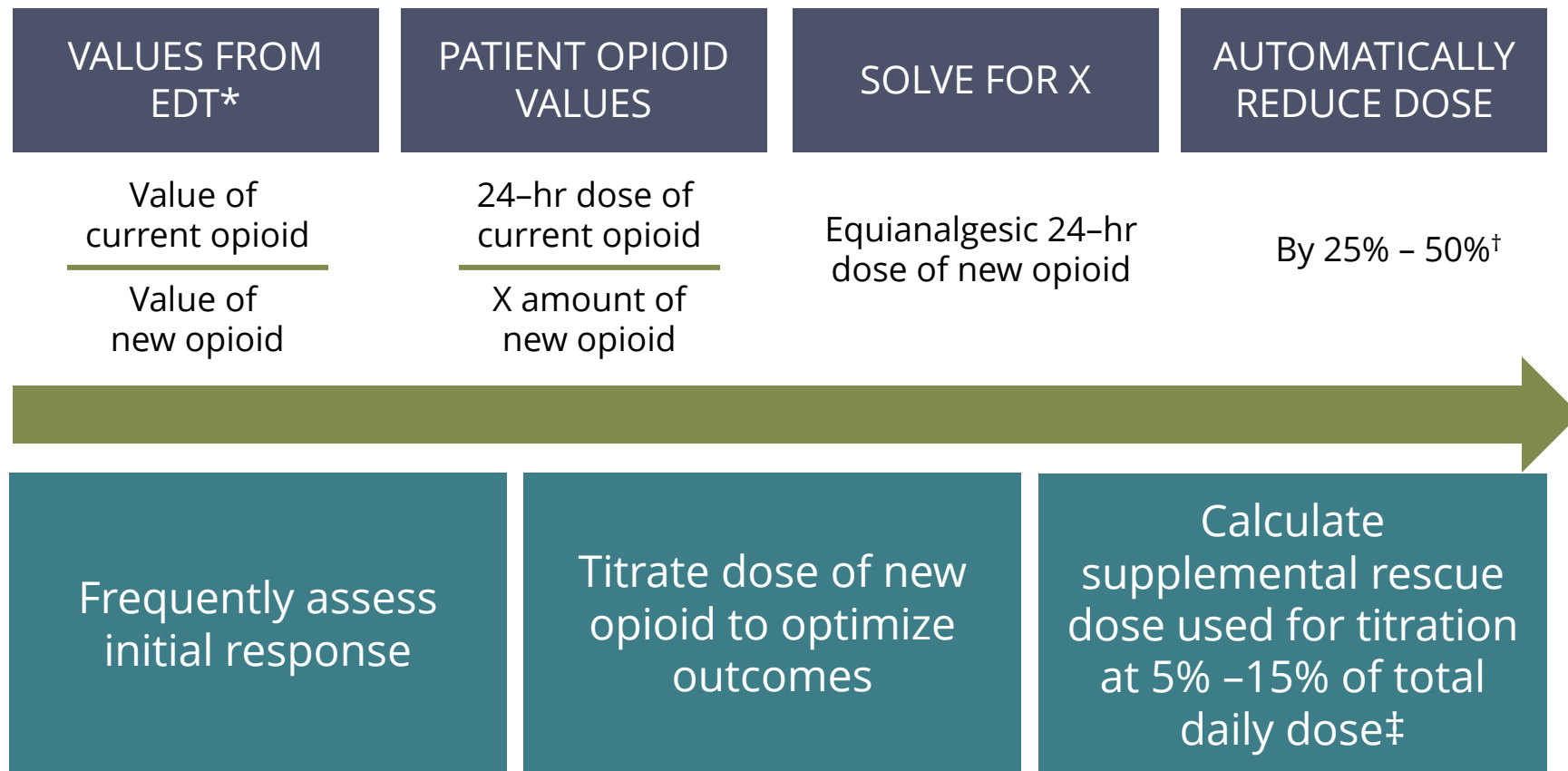
### IF SWITCHING TO METHADONE:

- Standard EDTs are less helpful in opioid rotation to methadone
- For opioid tolerant patients, methadone doses should **not** exceed 30 – 40 mg/day upon rotation
  - Consider inpatient monitoring, including serial EKG monitoring
- For opioid-naïve patients, do **not** give methadone as an initial drug

### IF SWITCHING TO TRANSDERMAL:

- **Fentanyl:** calculate dose conversion based on equianalgesic dose ratios included in the drug package insert

# GUIDELINES FOR OPIOID ROTATION: SUMMARY



\* If switching to transdermal fentanyl, use equianalgesic dose ratios provided in PI

<sup>†</sup> If switching to methadone, reduce dose by 75% – 90%

<sup>‡</sup> If oral transmucosal fentanyl used as rescue, begin at lowest dose irrespective of baseline opioid

## BREAKTHROUGH PAIN (BTP)

### PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP

- Due to disease progression or a new or unrelated pain
  - Target cause or precipitating factors
- Dose for BTP: Using an **IR, 5% – 15%** of total daily opioid dose, administered at an appropriate interval
- **Never use ER/LA for BTP**

### CONSIDER ADDING

- PRN IR opioid trial based on analysis of benefit versus risk
  - There is a risk for aberrant/problematic drug-related behaviors
  - High-risk: Add only in conjunction with frequent monitoring and follow-up
  - Low-risk: Add with routine follow-up and monitoring
- Consider non-opioid drug therapies and nonpharmacologic treatments

# ABUSE-DETERRENT FORMULATION (ADF) OPIOIDS

- Response to growing non-medical-use problem
- An ER/LA opioid with properties to meaningfully deter abuse, even if they do not fully prevent abuse
  - Less likely to be crushed, injected, or snorted
- Consider as one part of an overall strategy
- Mixed evidence on the impact of ADF on misuse
- Overdose is still possible if taken orally in excessive amounts
- These products are expensive with no generic equivalents



# URINE DRUG TESTING (UDT)



- Urine testing is done **FOR** the patient, not **TO** the patient
- Helps to identify drug misuse/addiction
- Assists in assessing and documenting adherence

## CLINICAL CONSIDERATIONS

- Recommend UDT before first prescription (baseline) then intermittently, depending on clinical judgment and state regulations
- Document time and date of last dose taken
- Be aware of possible false positives or negatives
- Clarify unexpected results with the lab before confronting patient to rule out poor specimen or error

# SCREENING VERSUS CONFIRMATORY UDTs

	SCREENING	CONFIRMATORY
<b>Analysis technique</b>	Immunoassay	GC-MS or HPLC
<b>Sensitivity</b> (power to detect a class of drugs)	Low or none when testing for semi-synthetic or synthetic opioids	High
<b>Specificity</b> (power to detect an individual drug)	Varies (can result in false positives or false negatives)	High
<b>Turnaround</b>	Rapid	Slow
<b>Other</b>	Intended for a drug-free population, may not be useful in pain medicine.	Legally defensible results

GC-MS = gas chromatograph-mass spectrometry; HPLC = high-performance liquid chromatography

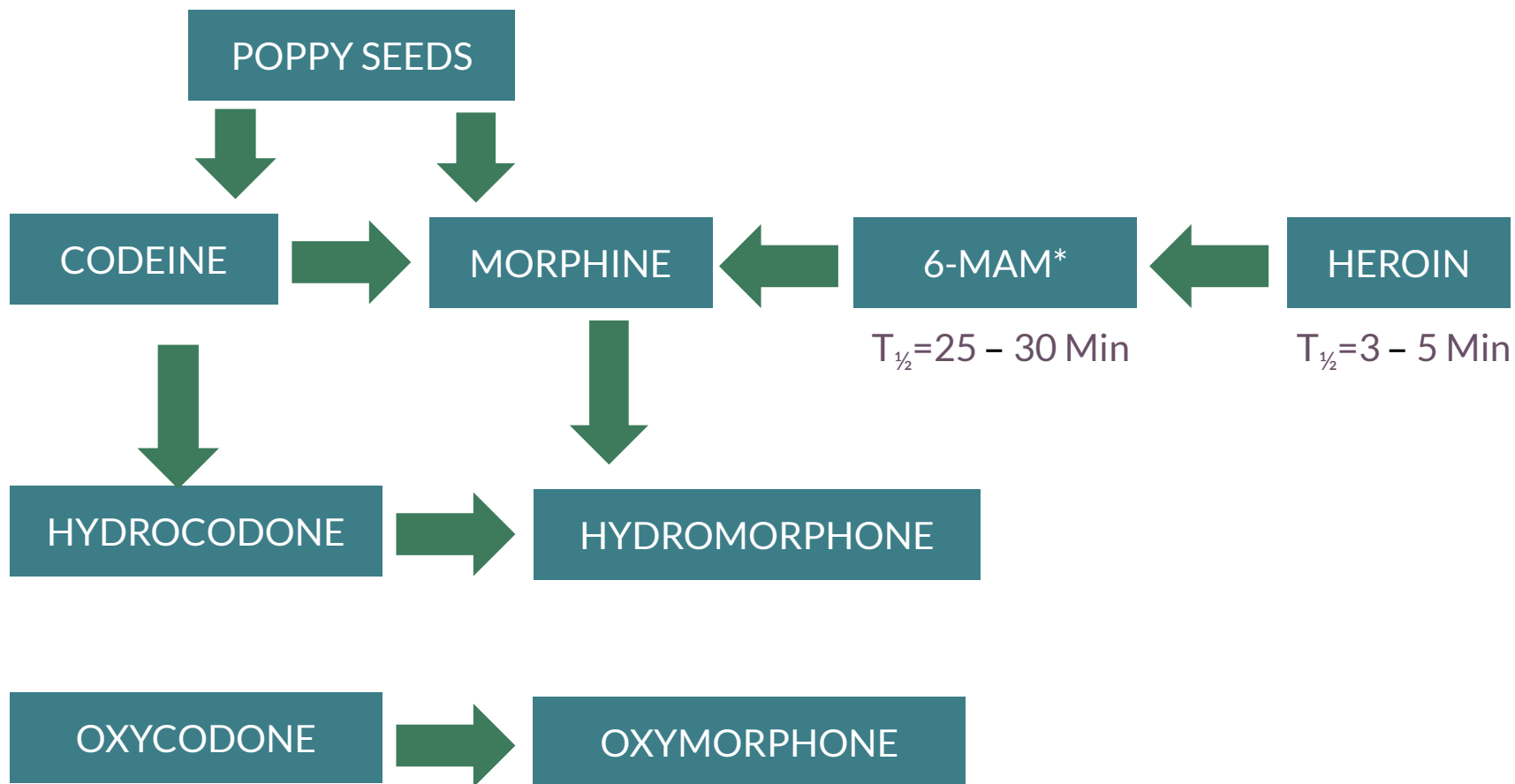


## WINDOWS OF SPECIFIC DRUG DETECTION

Drug	How soon after taking drug will there be a positive drug test?	How long after taking drug will there continue to be a positive drug test?
Cannabis/pot	1 – 3 hours	1 – 7 days
Crack (cocaine)	2 – 6 hours	2 – 3 days
Heroin (opiates)	2 – 6 hours	1 – 3 days
Speed/uppers (amphetamine, methamphetamine)	4 – 6 hours	2 – 3 days
Angel dust/PCP	4 – 6 hours	7 – 14 days
Ecstasy	2 – 7 hours	2 – 4 days
Benzodiazepine	2 – 7 hours	1 – 4 days
Barbiturates	2 – 4 hours	1 – 3 weeks
Methadone	3 – 8 hours	1 – 3 days
Tricyclic antidepressants	8 – 12 hours	2 – 7 days
Oxycodone	1 – 3 hours	1 – 2 days

SOURCE: <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/DrugsofAbuseTests/ucm125722.htm>

# EXAMPLES OF OPIOID METABOLISM



\*6-MAM=6-Monoacetylmorphine

# REASONS FOR DISCONTINUING OPIOIDS

PAIN LEVEL DECREASE  
IN STABLE PATIENTS

INTOLERABLE AND  
UNMANAGEABLE  
AEs

NO PROGRESS  
TOWARD  
THERAPEUTIC GOALS

## MISUSE OR ABERRANT BEHAVIORS

- One or two episodes of increasing dose without prescriber knowledge
- Sharing medications
- Unapproved opioid use to treat another symptom (e.g., insomnia)
- Use of illicit drugs or unprescribed opioids
- Repeatedly obtaining opioids from multiple outside sources
- Prescription forgery
- Multiple episodes of prescription loss
- Diversion

## OUD/SUD RISK ASSESSMENT TOOLS (ONCE TREATMENT BEGINS)



### PMQ

Pain Medication  
Questionnaire

### COMM

Current Opioid Misuse  
Measure

### PDUQ

Prescription Drug Use  
Questionnaire

### SBIRT

Screening, Brief  
Intervention, and Referral  
to Treatment

Even at prescribed doses, opioids carry the risk of misuse, abuse, opioid use disorder, overdose, and death

# TAPER DOSE WHEN DISCONTINUING

- No single approach is appropriate for all patients
- May use a range of approaches from a slow 10% dose reduction per week to a more rapid 25% – 50% reduction every few days
- To minimize withdrawal symptoms in patients physically dependent on opioids, consider medications to assist with withdrawal
- If opioid use disorder or a failed taper, refer to an addiction specialist or consider opioid agonist therapy
- Counseling and relaxation strategies needed



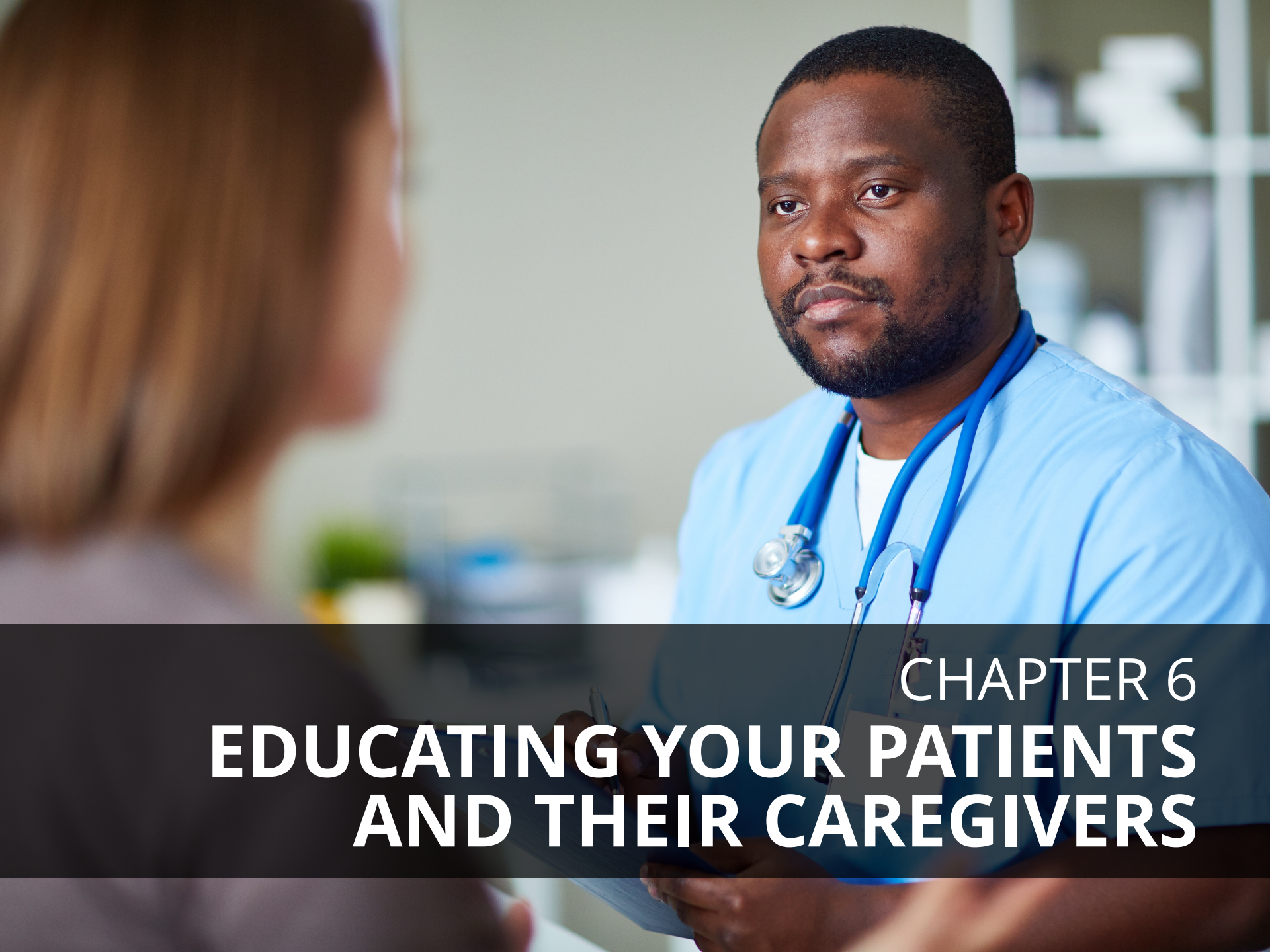
## CONSULTING A PAIN SPECIALIST

- Appropriate when you feel you cannot provide the level of care needed
- First ensure you have a reliable specialist to refer to
- To find a pain specialist in your area:
  - Consult with state boards
  - Consult with colleagues
  - Use online resources
  - Consult payment source
- Prior to referral, contact the specialist and ask what is needed for referral





Adequately **DOCUMENT**  
all patient interactions,  
assessments, test results,  
and treatment plans.



CHAPTER 6  
**EDUCATING YOUR PATIENTS  
AND THEIR CAREGIVERS**

# COUNSEL PATIENTS ABOUT PROPER USE

- Take opioid as prescribed
- Adhere to dose regimen
- Use least amount of medication necessary for shortest time
- Do not abruptly discontinue or reduce dose; taper safely to avoid withdrawal symptoms
- Properly handle missed doses
- Notify HCP if pain is uncontrolled
- Manage side effects
- Inform HCP of ALL meds being taken
- Never share or sell opioids: can lead to others' deaths, against the law
- Use caution when operating heavy machinery and driving



Read the opioid **drug package insert** received from the pharmacy **every time** an opioid is dispensed



# USE PATIENT COUNSELING DOCUMENT

## What You Need to Know About Opioid Pain Medicines

***This guide is for you!*** Keep this guide and the Medication Guide that comes with your medicine so you can better understand what you need to know about your opioid pain medicine. Go over this information with your healthcare provider. Then, ask your healthcare provider about anything that you do not understand.

### ***What are opioids?***

Opioids are strong prescription medicines that are used to manage severe pain.

### ***What are the serious risks of using opioids?***

- Opioids have serious risks of addiction and overdose.
- **Too much opioid medicine in your body can cause your breathing to stop – which could lead to death.** This risk is greater for people taking other medicines that make you feel sleepy or people with sleep apnea.
- **Addiction** is when you crave drugs (like opioid pain medicines) because they make you feel good in some way. You keep taking the drug even though you know it is not a good idea and bad things are happening to you. Addiction is a brain disease that may require ongoing treatment.

### ***Risk Factors for Opioid Abuse:***

- You have:
  - » a history of addiction
  - » a family history of addiction

- Take your opioid medicine exactly as prescribed.
- Do not cut, break, chew, crush, or dissolve your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider.
- When your healthcare provider gives you the prescription, ask:
  - » How long should I take it?
  - » What should I do if I need to taper off the opioid medicine (slowly take less medicine)?
- Call your healthcare provider if the opioid medicine is not controlling your pain. Do not increase the dose on your own.
- **Do not share or give your opioid medicine to anyone else.** Your healthcare provider selected this opioid and the dose just for **you**. A dose that is okay for you could cause an overdose and death for someone else. Also, it is against the law.
  - Store your opioid medicine in a safe place where it cannot be reached by children or stolen by family or visitors to your home. Many teenagers like to experiment with pain medicines. Use a lock-box to keep your opioid



CLICK TO DOWNLOAD

[https://www.accessdata.fda.gov/drugsatfda\\_docs/rems/Opioid\\_Analgesic\\_2018\\_09\\_18\\_Patient\\_Counseling\\_Guide.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_Analgesic_2018_09_18_Patient_Counseling_Guide.pdf)

# PROVIDE ANTICIPATORY GUIDANCE ON OPIOID SIDE EFFECTS AND ADVERSE EVENTS

- Respiratory depression: most serious
- Opioid-induced constipation (OIC): most common
- Sexual dysfunction and other endocrine abnormalities
- Tolerance, physical dependence, hyperalgesia
- Allergic reactions
- Sedation, cognitive impairment
- Falls and fractures
- Sweating, miosis, urinary retention
- Hypogonadism
- Myoclonus (twitching or jerking)
- Addiction in vulnerable patients
- Overdose and death



## WARN PATIENTS

### Never break, chew, crush, or snort an opioid tablet/capsule, or cut or tear patches or buccal films prior to use

- May lead to rapid release of opioid, causing overdose and death
- If patient is unable to swallow a capsule whole, refer to drug package insert to determine if appropriate to sprinkle contents on applesauce or administer via feeding tube



### Use of CNS depressants or alcohol with opioids can cause overdose and death

- Use with alcohol may result in rapid release and absorption of a potentially fatal opioid dose, known as “dose dumping”
- Use with other depressants such as sedative-hypnotics (benzodiazepines), anxiolytics, or illegal drugs can cause life-threatening respiratory depression





# OPIOID-INDUCED RESPIRATORY DEPRESSION

If not immediately recognized and treated, may lead to respiratory arrest and death

**Greatest risk:**  
during initiation of therapy or after dose increase

## Instruct patients/family members to:

- Screen for shallow or slowed breathing
- Deliver naloxone
- **CALL 911**

**Instructions may differ if patient is on hospice or near end of life**

## SIGNS OF OVERDOSE POISONING **CALL 911**

- Person cannot be aroused or awakened or is unable to talk
- Any trouble with breathing, heavy snoring is warning sign
- Gurgling noises coming from mouth or throat
- Body is limp, seems lifeless; face is pale, clammy
- Fingernails or lips turn blue/purple
- Slow, unusual heartbeat or stopped heartbeat



# NALOXONE

## What it is:

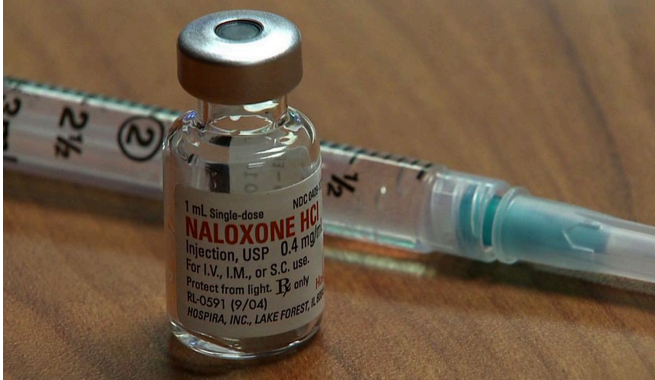
- An opioid antagonist administered intranasally (most common) or parenterally
- Reverses acute opioid-induced respiratory depression but will also reverse analgesia; may precipitate acute opioid withdrawal

## What to do:

- Discuss an overdose plan with patients
- Consider offering a naloxone prescription to all patients prescribed opioids; some states *require* co-prescribing
- Involve and train family, friends, partners, and/or caregivers in the proper administration of naloxone
- Check to see if pharmacy dispenses it
- Check expiration dates and replace expired naloxone
- In the event of known or suspected overdose **call 911** and administer naloxone

# NALOXONE OPTIONS

- Available as auto-injector, intramuscular injection, or nasal spray
- Cost and insurance coverage vary
- Make use of tutorial videos to demonstrate administration
- Store at room temperature
- Dispose of used containers safely



Naloxone vials



Narcan nasal spray



Evzio (auto-injector)

Trade names are used for identification purposes only and do not imply endorsement.

SOURCE: FDA Information About Naloxone,  
<https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm472923.htm>

# SAFE OPIOID STORAGE AND DISPOSAL



## STEP 1: MONITOR

- Note how many pills are in each prescription
- Keep track of dosage and refills
- Make sure everyone in the home knows

## STEP 2: SECURE

- Keep meds in a safe place (locked cabinet or box)
- Store away from children, family, visitors, and pets
- Encourage parents of your teen's friends to secure their prescription

## STEP 3: DISPOSE

- Discard expired or unused meds
- Consult drug package insert for best disposal method

SOURCE: McDonald E, Kennedy-Hendrick A, McGinty E, Shields W, Barry C, Gielen A. Pediatrics. 2017;139(3):e20162161

# WHERE AND HOW TO DISPOSE OF UNUSED OPIOIDS



## Authorized Collection Sites

- Use the DEA disposal locator website to find sites near you:  
<https://apps.deadiversion.usdoj.gov/pubdispsearch>
- Search Google Maps for "drug disposal nearby"



## Mail-Back Packages

- Obtain from authorized collectors



## Other Options

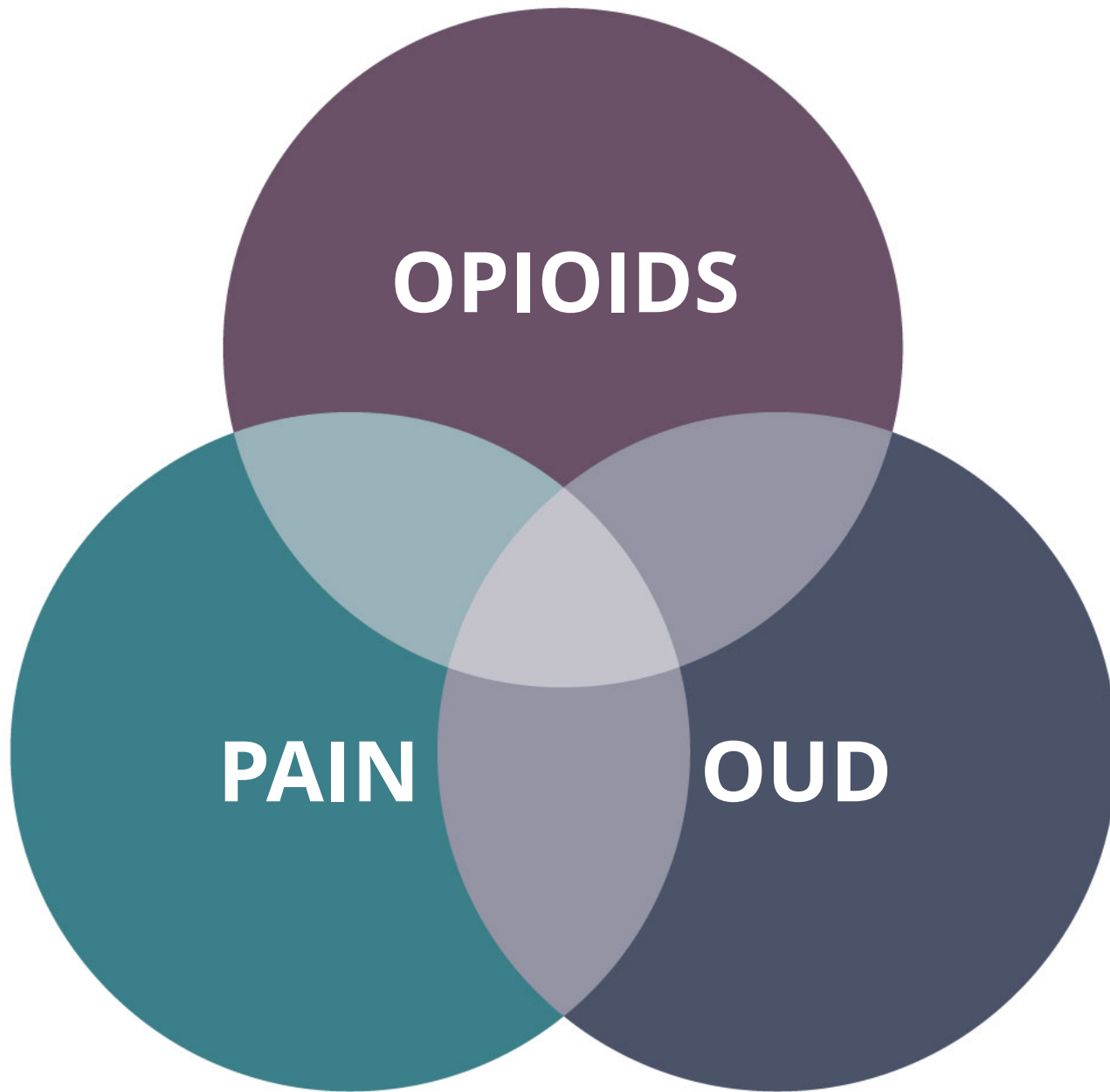
- Drug take-back days (local pharmacies or local law enforcement)
- Flush
- Trash (mix with noxious element)
- Fold patch in half so sticky sides meet, then flush

SOURCES. Department of Justice, Diversion Control Division, Disposal Act: General Public Fact Sheet (June 2018), [https://www.deadiversion.usdoj.gov/drug\\_disposal/fact\\_sheets/disposal\\_public\\_06222018.pdf](https://www.deadiversion.usdoj.gov/drug_disposal/fact_sheets/disposal_public_06222018.pdf);  
FDA. Where and How to Dispose of Unused Medicines, <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm>





CHAPTER 7  
**UNDERSTANDING OPIOID  
USE DISORDER (OUD)**



# OPIOIDS

## WHAT IS THE RISK FOR MY PATIENT?

- Risk of opioid use disorder in patients on chronic opioid therapy (COT) for chronic non-cancer pain (CNCP) is up to **26%**
- Risk is always highest with past history of substance use disorder (SUD) or psychiatric comorbidity

SOURCE: Boscarino, J. Addictive Dis., 2011;30(3):185-194, <http://www.tandfonline.com/doi/abs/10.1080/10550887.2011.581961>

# WHAT IS ADDICTION?



## OFFICIAL ASAM DEFINITION:

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

## PRACTICAL DEFINITION:

Addiction is the continued use of drugs or activities, despite knowledge of continued **harm** to one's self or others.

# SUBSTANCE USE DISORDER: DSM-5 CRITERIA

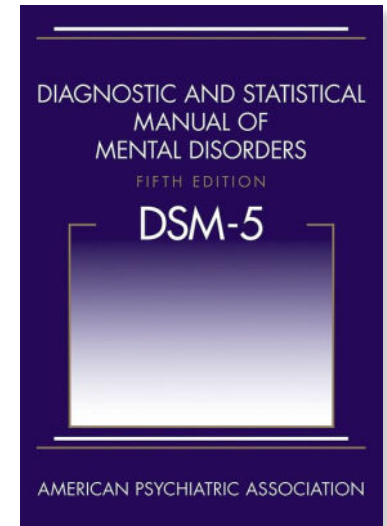
1. Tolerance\*
2. Withdrawal\*

## LOSS OF CONTROL

3. Using larger amounts and/or for longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using, or recovering
6. Craving/compulsion

## USE DESPITE NEGATIVE CONSEQUENCES

7. Role failure at work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm



- 2 – 3 = mild
- 4 – 5 = moderate
- $\geq 6$  = severe

**\* Not valid if opioid is taken as prescribed**

SOURCE: APA. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 2013

## PAIN, OUD, AND OPIOIDS

The DSM-5 criteria for opioid use disorder may be misleading in the context of *prescribed opioids* for the treatment of pain.

**The usual illegal, illicit issues do not pertain.**

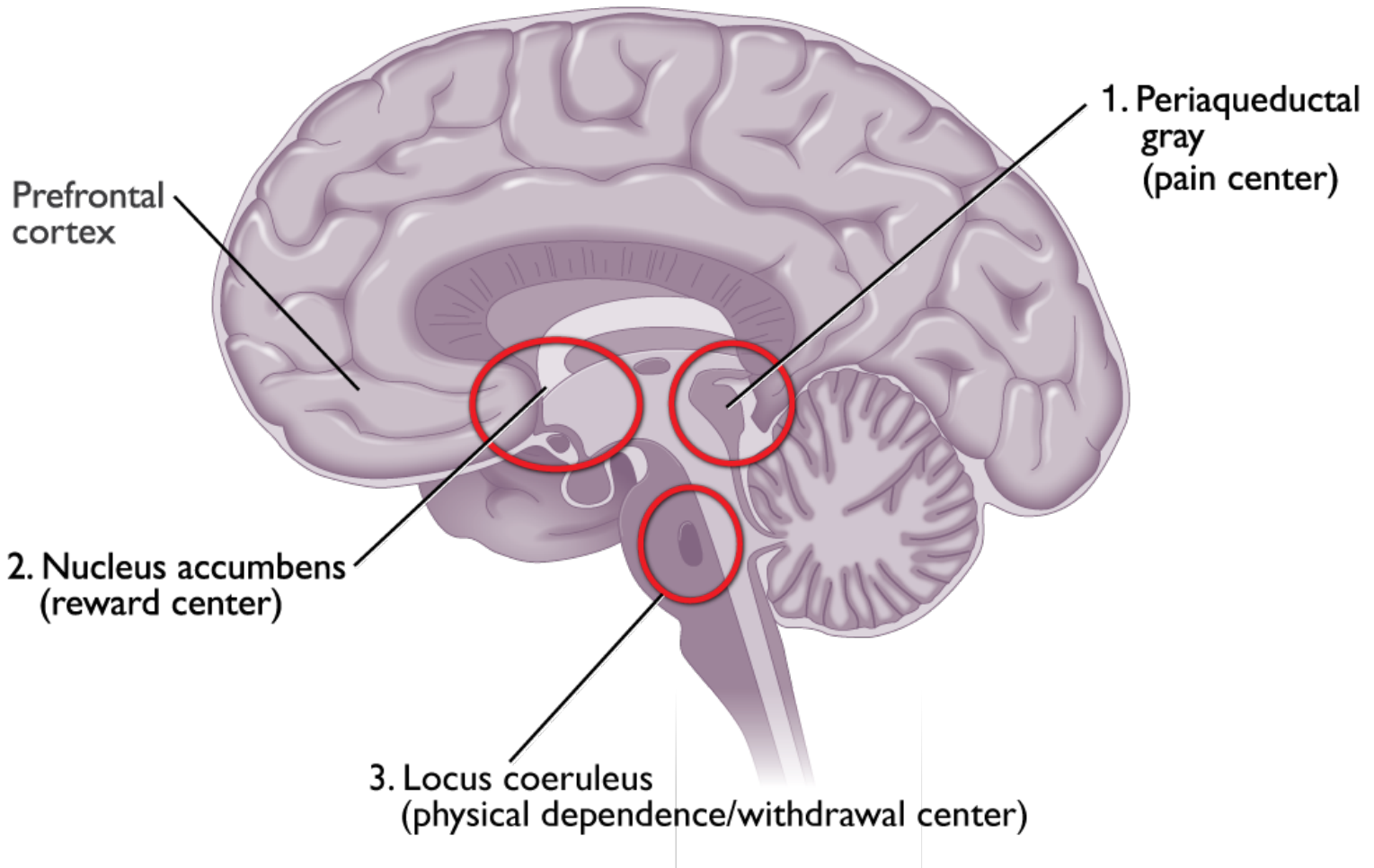
**Harm may be masked under these conditions.**



# WORDS MATTER



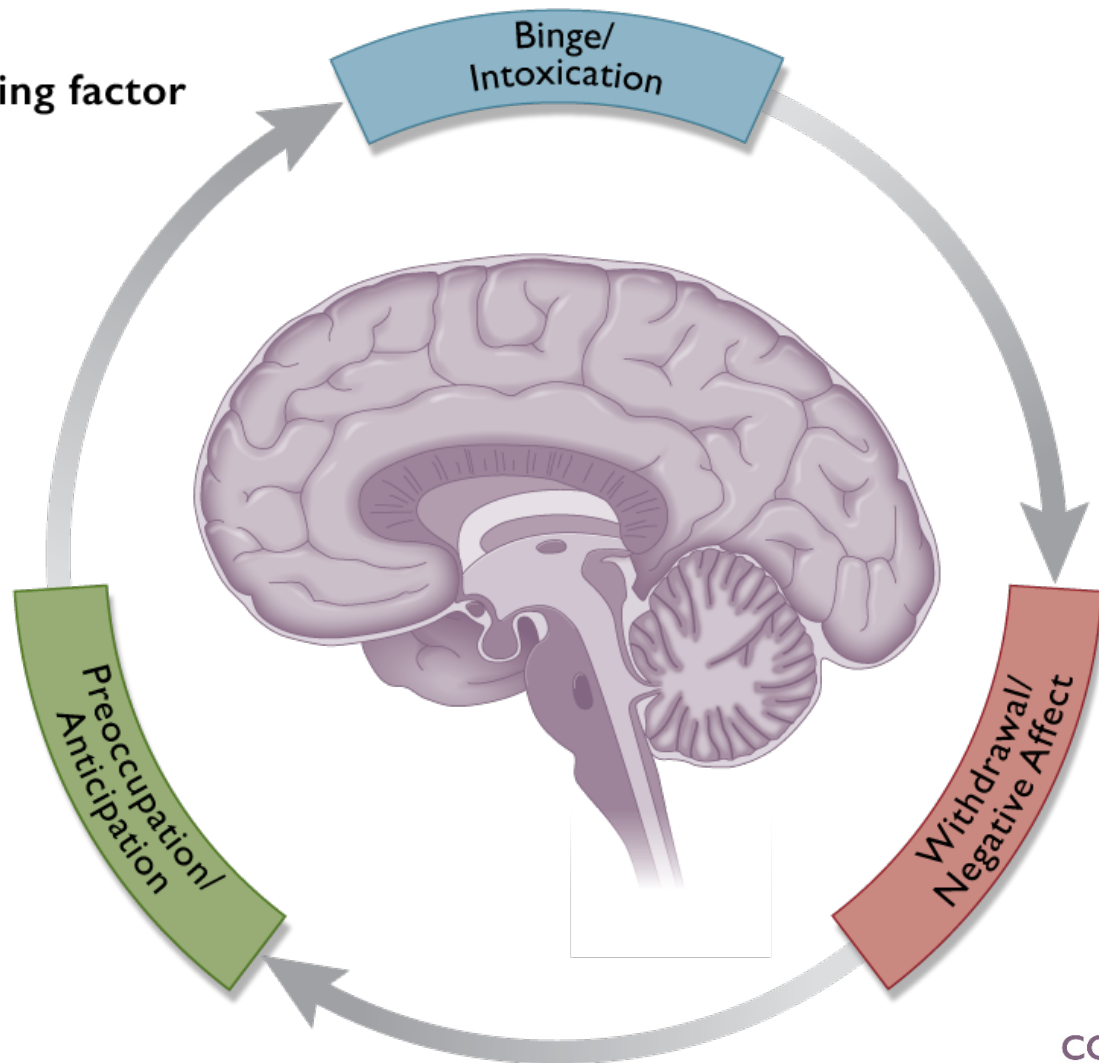
# OPIOID RECEPTORS IN THE BRAIN: RELATIONSHIP TO ANALGESIA, OUD, AND WITHDRAWAL



# THE CYCLE OF SUBSTANCE USE DISORDER

## NEUROTRANSMITTERS

- Dopamine
- Opioid peptides
- Corticotropin-releasing factor
- Dynorphin
- Glutamate

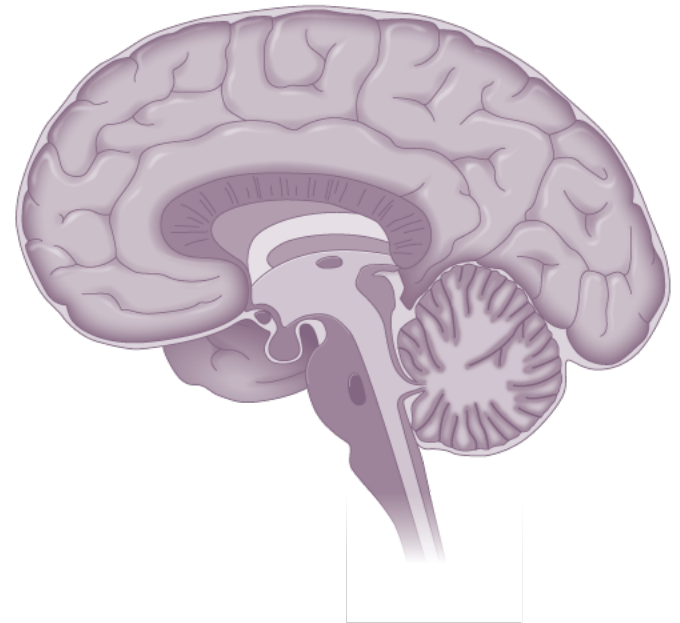


# WHO IS VULNERABLE TO OPIOID MISUSE OR OUD?

Those with psychiatric comorbidities

19% of people who have mental health disorders in United States receive 51% of the prescribed opioids.

The probability of long-term opioid use increases most sharply in the first days of therapy, particularly after 5 days or 1 month of opioids has been prescribed.



# TREATMENT OF OPIOID USE DISORDER

- Medication options for addiction treatment (MAT)
  - Methadone (Schedule II)
  - Buprenorphine (Schedule III)
  - Naltrexone (not a controlled substance)
- Supplementary psychosocial and recovery support services
  - Housing, childcare, support groups, employment services
- Temporal considerations
  - Frequency of administration (daily versus long-acting formulations)
  - Length of treatment
    - No recommended time period for treatment
    - Patients who discontinue and resume risk overdose and death

# TREATING PAIN IN THE PATIENT WITH OUD

- Remember that untreated pain is a trigger for relapse
- Must address *both* pain and opioid use disorder
- Avoid other potentially problematic medications
- Consider a multidisciplinary pain program

- Consider buprenorphine for both pain and OUD
- Consider using opioids that do not metabolize to other prescribed medications
- Enlist patient's family/ significant other to secure and dispense opioids
- Recommend an active recovery program
- Remember to use UDT, PDMP, pill counts, PPA

SOURCE: Bailey J, et al. Pain Med 2010;11:1803-1818.



# OPIOID ANALGESICS WITH BENZODIAZEPINES, NICOTINE, AND ALCOHOL

- More than 30% of opioid overdoses involve benzodiazepines (BZDs); both are CNS depressants
- Nicotine and alcohol use are risk factors for misuse of prescribed opioids
- Nicotine users are co-prescribed BZDs and muscle relaxants (MRs) with opioids to a greater extent than non-nicotine users



SOURCE: NIDA. Takaki H, et al. Am Journal Addictions. 2019;1-8.

# BUPRENORPHINE

- If using for pain, you don't need a waiver
- If using to treat OUD, you need a waiver
- The most commonly prescribed pharmacotherapy for the treatment of OUD
- Partial mu-agonist with “plateau effect” for respiratory depression
- Good efficacy and safety profile
- FDA-approved buprenorphine products for pain:
  - Butrans: 7-day transdermal patch
  - Belbuca: buccal mucosal film; BID dosing

# REFERRALS AND TREATMENT CENTERS

ASAM, SAMHSA, and AAP are all helpful referral resources.

ASAM resources: <https://www.asam.org/resources/resource-links>

SAMHSA locator: <https://findtreatment.samhsa.gov/locator>

AAP locator: <https://www.aap.org/patients/find-a-specialist/>

The image displays two screenshots of professional websites. The left screenshot shows the ASAM (American Society of Addiction Medicine) website. It features a navigation menu with 'ADVOCACY', 'EDUCATION', 'MEMBERSHIP', and 'RESOURCES'. Below the menu is a 'Search Membership Directory' section with a 'Search Fields' form. The form includes input fields for 'First Name', 'Last Name', 'City', 'State (2-letter postal code)', 'ZIP/Postal Code', and 'Country'. There are also three dropdown menus for certification types: 'American Board of Preventive Medicine certified?', 'American Board of Psychiatry and Neurology certified?', and 'American Board of Addiction Medicine certified?'. A 'Search' button is at the bottom of the form. The right screenshot shows the SAMHSA (Substance Abuse and Mental Health Services Administration) website. It has a dark header with 'Find Help & Treatment' as the active menu item, along with 'Grants', 'Data', 'Programs & Campaigns', 'Newsroom', 'About Us', and 'Publications'. The main content area is divided into three columns: 'NATIONAL SUICIDE PREVENTION LIFELINE' with phone numbers 1-800-273-8255 and 1-800-799-4889; 'NATIONAL HELPLINE' with phone numbers 1-800-662-HELP and 1-800-487-4889; and 'Disaster Distress Helpline' with phone numbers 1-800-985-5990 and 1-800-846-8517. A 'Treatment Locators' section on the right lists various services with location pins, including 'Behavioral Health Treatment Services Locators', 'Buprenorphine Physician & Treatment Program Locator', 'Early Serious Mental Illness Treatment Locator', and 'Opioid Treatment Program Directory'. A search bar is visible at the top right of the SAMHSA page.

Our session stops here, but your review continues...

For detailed information, prescribers can refer to prescribing information available online via DailyMed at [www.dailymed.nlm.nih.gov](http://www.dailymed.nlm.nih.gov) or <https://opioidanalgesicrems.com/RpcUI/products.u>

Please visit the CO\*RE Tools Repository <http://core-rems.org/opioid-education/tools/>

# YOUR PARTICIPATION IS IMPORTANT

Thank you for completing the post test  
for this CO\*RE session.

**Your participation in this test allows CO\*RE to report  
de-identified numbers to the FDA.**

Strong test participation will demonstrate that clinicians have voluntarily  
engaged with this important material and are committed to  
patient safety and improved outcomes.

# THANK YOU!

# THANK YOU!

[WWW.CORE-REMS.ORG](http://WWW.CORE-REMS.ORG)

