

Chronic Opioid Therapy for Chronic Pain

December 2019

This CPM presents a model of care based on scientific evidence available at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative.

Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base.

If you have questions or concerns regarding this information, contact:

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This CPM is part of Presbyterian's Clinical Care Model, a broad, enterprise-wide body of documentation covering PHS' functions, programs, and care pathways, intended to build organizational acumen, facilitate cross-system collaboration, and accelerate our implementation of clinical initiatives.

Find all of PHS' Care Model at www.PHSCareModel.org.

This Clinical Practice Model (CPM) summarizes evidence-based guidelines for:

- Adult patients over the age of 18
- With indications for opioid therapy for chronic pain
- Outside of treatment of malignant cancer, palliative care, and end-of-life care

PHS Primary Care and Behavioral Health leadership offers clinicians this guidance to address the complexity of treating chronic pain patients with opioid medication.

Why Focus on Opioids?

New Mexico's drug overdose death rate has been one of the highest in the nation for most of the last two decades. In 2017, 332 New Mexicans died of opioid-related drug overdose, a rate of 16.7 deaths per 100,000 persons, compared to the national rate of 14.6 deaths per 100,000. Of those deaths, 171 were due to prescription opioids.

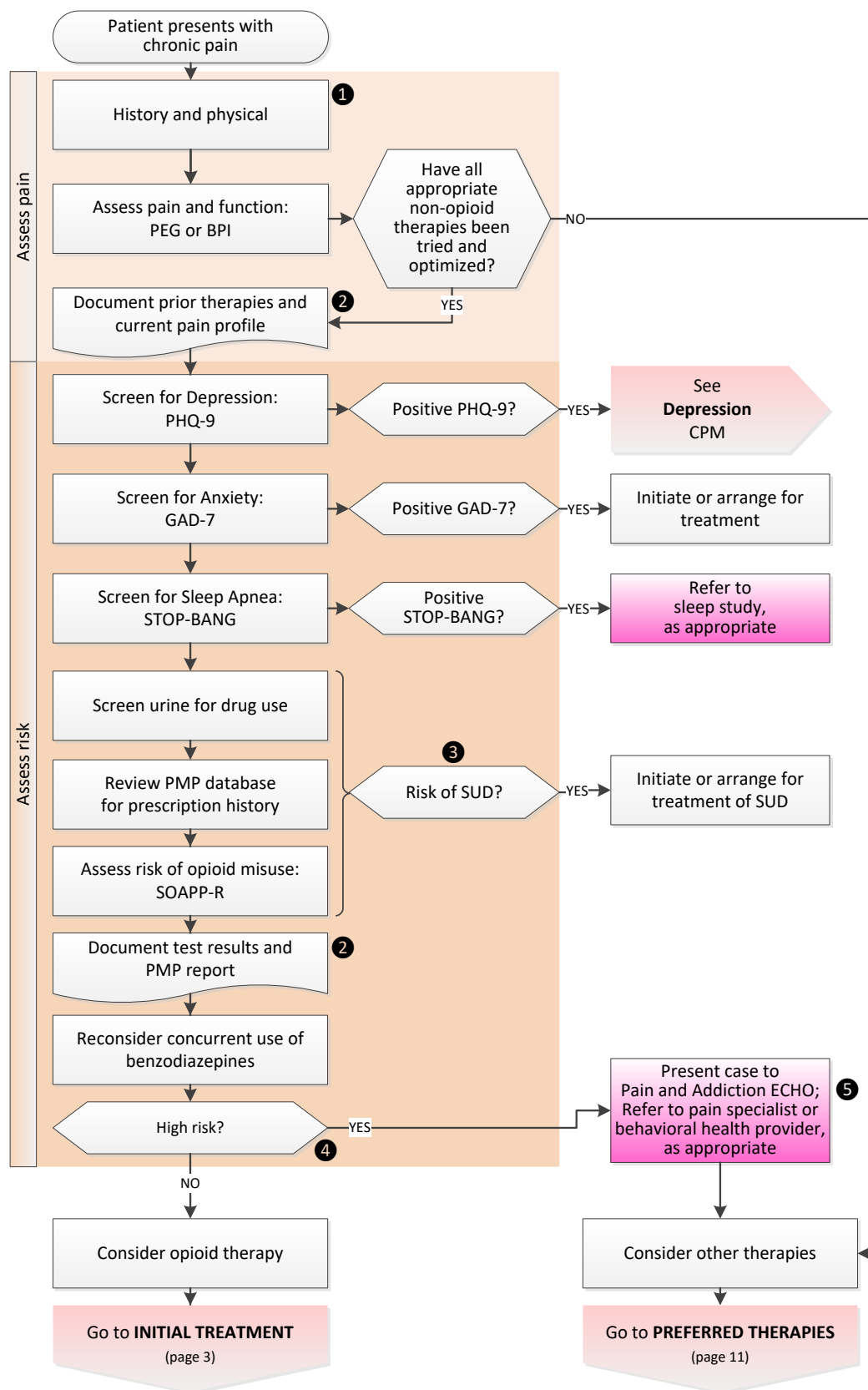
ED visits for opioid overdoses rose 30% in all parts of the US from July 2016 through September 2017. In New Mexico, opioid overdose related Emergency Department (OOR-ED) visits were 52.3 per 100,000 population, which is a slight (4%) decrease since 2016, but still up 56% since 2013. In 2018 there were 4,012 distinct encounters involving opioids in Presbyterian EDs; 107 of those involved opioid overdose.

Studies show that opioid pain medication use presents serious risks, including overdose and opioid use disorder. Moreover, several non-pharmacologic (e.g., cognitive behavioral therapy, exercise therapy, interventional treatments, and multimodal pain treatment) and non-opioid pharmacologic treatments (e.g., acetaminophen, NSAIDs, antidepressants, and anticonvulsants) have been shown to be effective in managing chronic pain. Clinical practice guidelines, like this one, may improve clinician knowledge, change prescribing practices, improve patient safety, and ultimately benefit the patient's health.

Care Pathway Roles and Responsibilities

Responsibility	Clinician
• Documents pain score at time of visit; ensures current PMP is on file; verifies medication agreement is current	Primary Support MA/LPN
• Clinical assessment; diagnosis; treatment	Provider
• Reviewing PMP report before prescribing and every 4 months continuing; documenting PMP report in the patient's medical record	Provider
• Pain management consultation	Pharmacist Clinician
• Pain management consultation	Pain Specialist
• Pain management consultation	Behavioral Health Provider

Initial Assessment



Opioid therapy should be initiated only when all three criteria are met:

- ☐ The pain is moderate to severe, adversely affecting the patient's function and/or quality of life;
- ☐ Adequate trials of other treatments and non-opioid analgesics have failed;
- ☐ The potential benefits of opioid therapy outweigh the risks.

The primary goal of chronic pain management is relief of suffering and improvement in function. This goal does not imply the complete absence of pain, which for many chronic pain patients is unrealistic.

NOTES:

1 Review patient use of non-opioid therapies, including physical therapy, exercise, diet, complementary therapies, and procedures.

Discuss personal and family history of opioid use, substance use, misuse, and addiction.

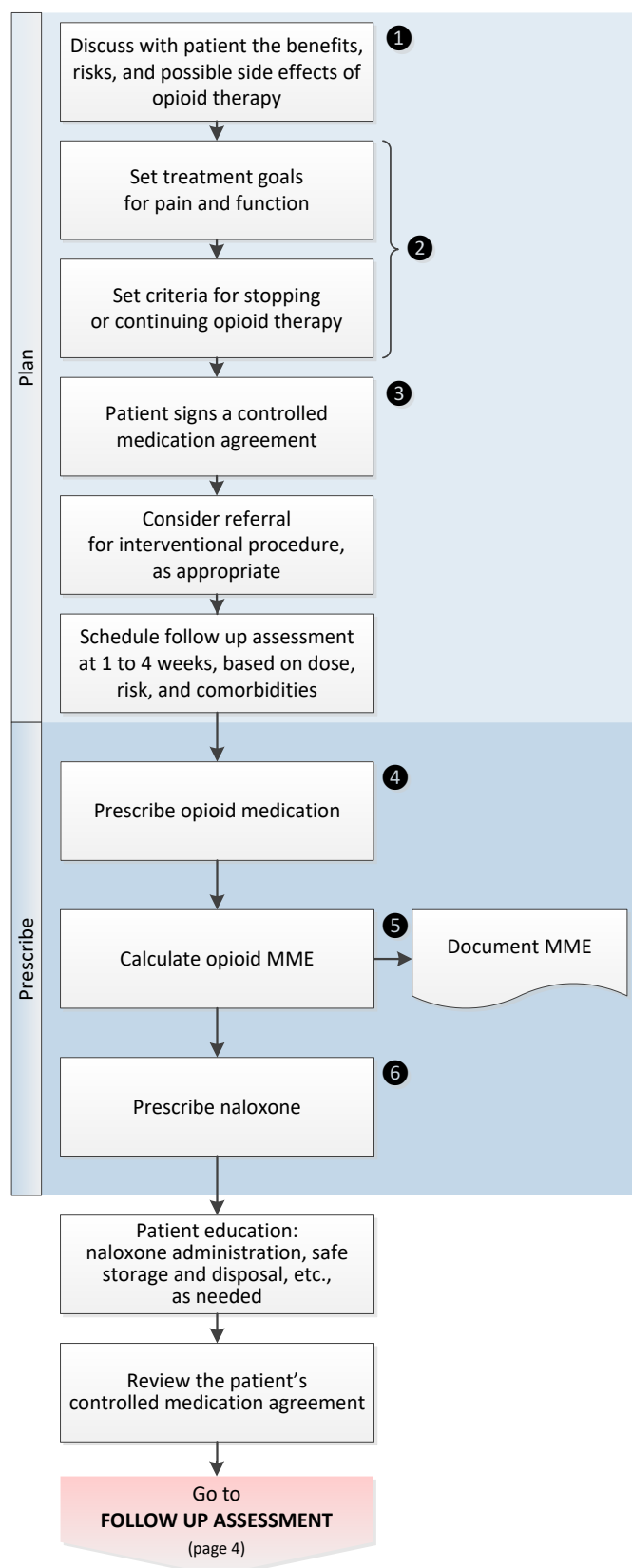
2 Document the patient's condition according to NMAC [documentation standards](#), page 9.

3 Evaluate the likelihood of opioid misuse: see [table](#), page 9.

4 Evaluate the risk of harm or misuse: see [table](#), page 10.

5 To present a case, email the clinic coordinator at PA_ECHO@phs.org

Initial Treatment with Opioid Medication



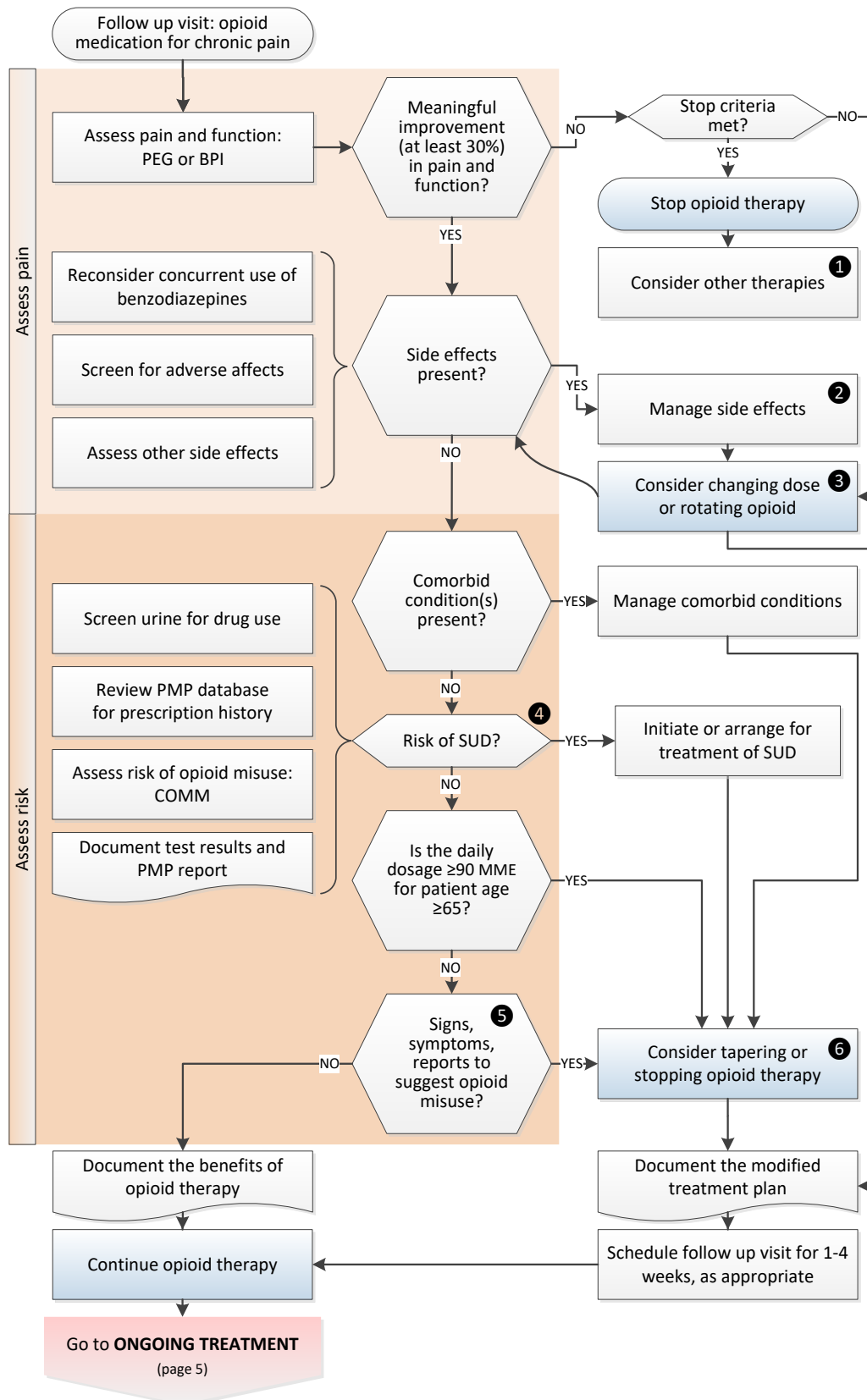
To initiate opioid therapy:

- ☐ The patient, after being informed of the risks and benefits and educated regarding the use of opioid medication, signs a controlled substance agreement.
- ☐ Set measurable, realistic treatment goals for pain and function.
- ☐ Prescribe immediate-release (IR) opioids instead of extended-release/ long-acting (ER/LA) opioids.
- ☐ Start low, and go slow: prescribe the lowest effective dosage.

NOTES:

- 1 [Involve patients in decisions](#) about their opioid therapy.
- 2 [Set realistic goals](#) for pain and function, and plan how and when opioid therapy would be discontinued.
- 3 Access the [Controlled Medication Treatment Agreement](#) on the PEL.
[Prescribe initially](#) a short-acting opioid using the lowest effective dosage. Match duration of prescription to the scheduled follow up assessment
- 4 Combine opioid therapy with [non-pharmacologic therapy](#) and [non-opioid pharmacologic therapy](#), as appropriate.
- 5 See [Calculating MME](#), p. 13.
- 6 [Naloxone](#) prescription is a strategy that may mitigate risk when the patient has a history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use.

Follow Up Assessment



Re-assess the patient for clinically meaningful improvement in pain and function (compare to baseline); re-evaluate risks to patient safety. Document any observed benefits.

NOTES:

① Combine opioid therapy with [non-pharmacologic therapy](#) and [non-opioid pharmacologic therapy](#), as appropriate.

② See [Managing Side Effects](#), p. 15.

③ Avoid increasing dosage to ≥90 MME/day, or carefully justify a decision to titrate dosage to ≥90 MME/day.

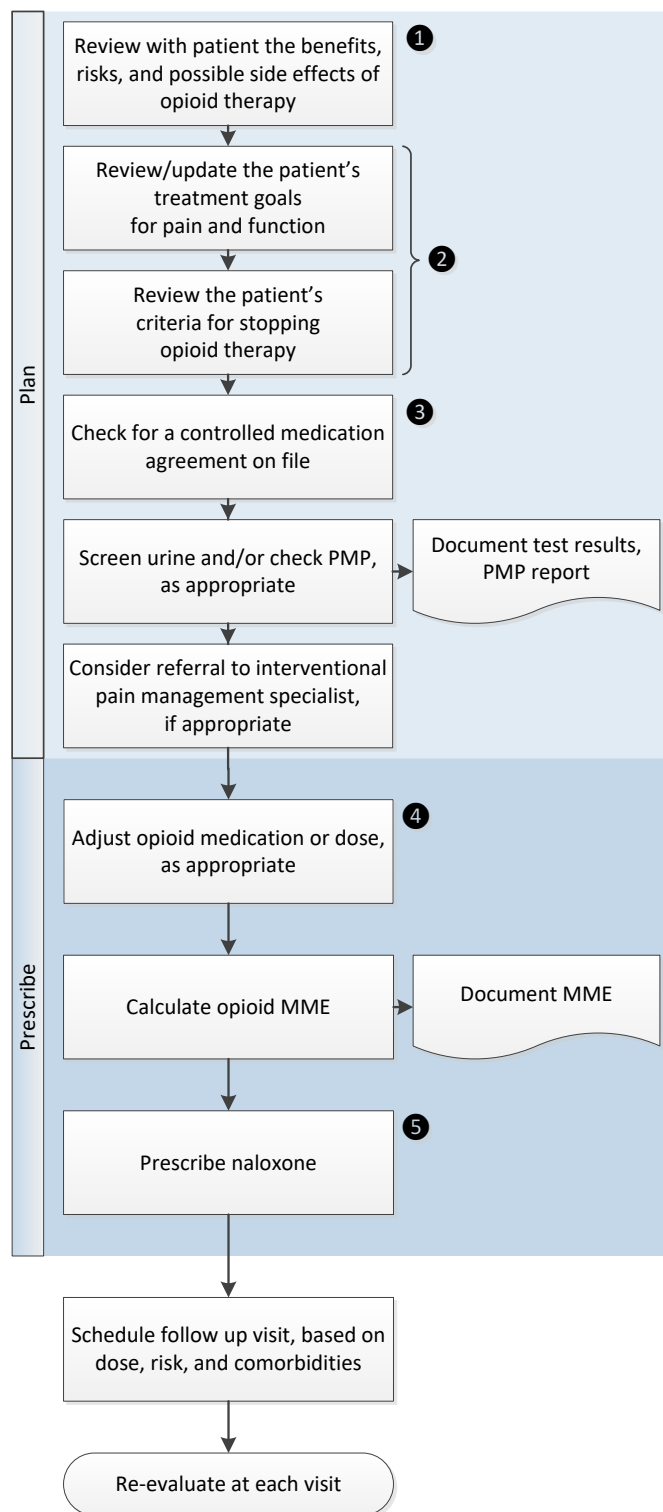
See [Increasing Dosage](#), p. 14, and [Rotation](#), p. 16.

④ Evaluate the likelihood of a substance use disorder: see Risk of Opioid Misuse [table](#), p. 9.

⑤ Be on alert for signs or symptoms that the patient may be misusing opioids. See [Reasons to Suspect Misuse](#), p. 15.

⑥ See [Tapering](#), p. 17.

Ongoing Treatment with Opioid Medication



Ongoing:

For a specific diagnosis, continue chronic opioid therapy only if the treatment plan results in clinically meaningful improvement in pain and function that outweighs risks to patient safety. Document the benefits. Check that the prescription is not being misused or diverted.

If there is ever an overdose, find an alternative treatment.

NOTES:

① [Involve patients in decisions](#) about their opioid therapy.

② [Maintain realistic goals](#) for pain and function, and plan how and when opioid therapy would be discontinued.

③ During continuous opioid therapy, obtain a PMP report every 3 months, and screen for urine toxicology every 6 months, at minimum.

④ Combine opioid therapy with [non-pharmacologic therapy](#) and [non-opioid pharmacologic therapy](#), as appropriate.

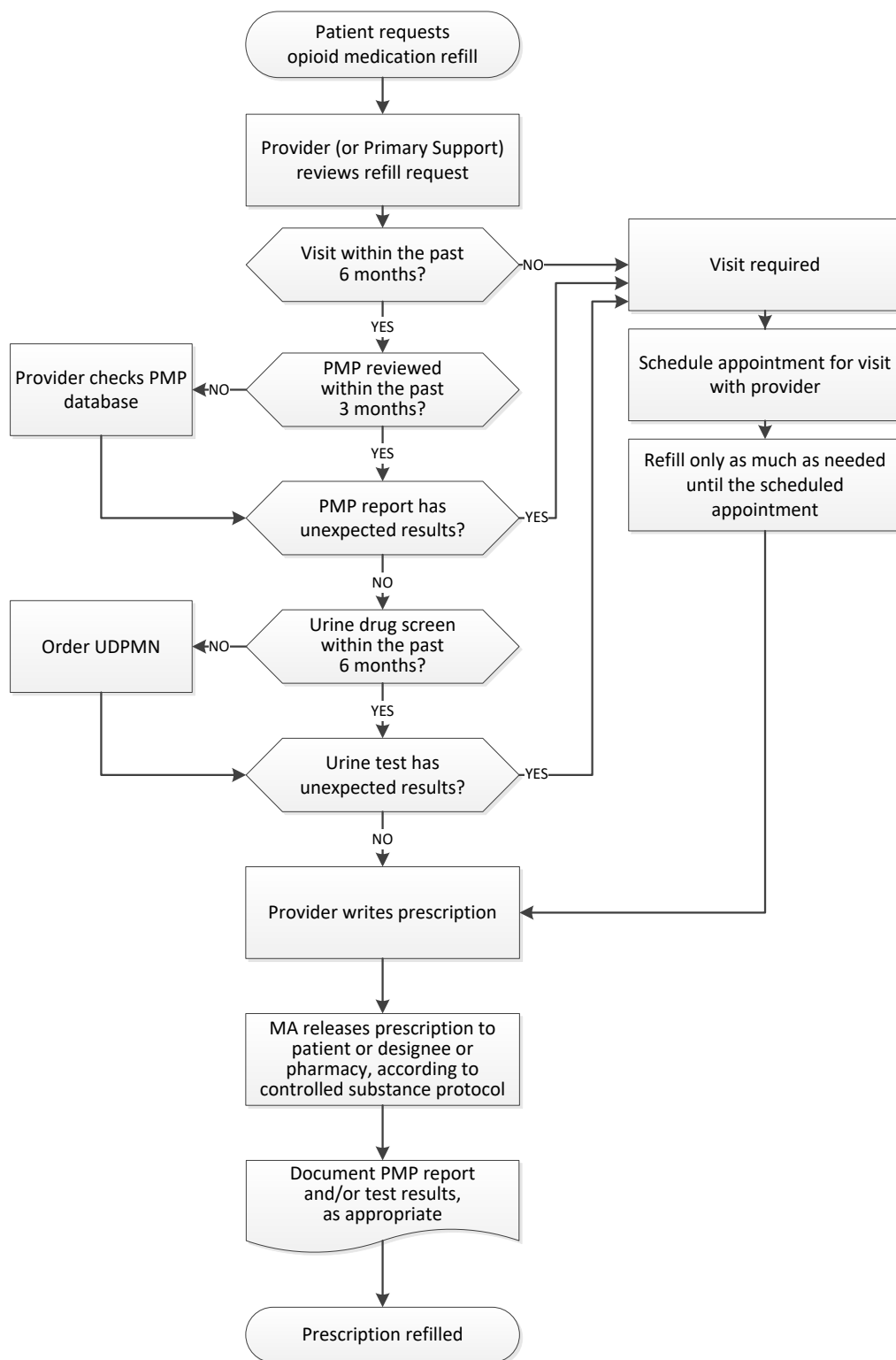
See [Increasing Dosage](#), p. 14.

See [Rotation](#), p. 16.

See [Tapering](#), p. 17.

⑤ [Naloxone](#) prescription is a strategy that may mitigate risk when the patient has a history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use.

Refilling Prescriptions for Opioid Medication



Controlled Substance Refill Policy:

A provider visit may be required to refill a patient's prescription for a controlled substance. A visit is warranted when:

- there is a need to change dosage or medication
- routine follow up (a pain and function assessment) is due
- unexpected results come from a PMP report or urine drug screen
- aberrant behavior is observed

Assessment

Evaluation should include:

- Assessment of pain and function (See [PEG](#).)
- Focused history, including history and characteristics of pain and potentially contributing factors (e.g., function, psychosocial stressors, sleep)
- Physical exam, with imaging or other diagnostic testing only if indicated (e.g., if severe or progressive neurologic deficits are present or if serious underlying conditions are suspected)

For complex pain syndromes, pain specialty consultation may be considered to assist with diagnosis as well as management.

PEG Assessment Scale

The pain average, interference with enjoyment of life, and interference with general activity (PEG) score is the average of the three individual item scores. The [PEG form](#) uses a 10-point scale, so patients can assess three aspects of their pain: the intensity; the degree the pain interferes with their enjoyment of life; and the degree it interferes with their general activity. To calculate the PEG score: $[Q1 + Q2 + Q3] / 3$

The final PEG score can mean very different things for different patients. Like most other screening instruments, it is most useful in tracking changes over time. The PEG score should decrease over time after therapy has begun.

A 30% improvement in pain and function is considered clinically meaningful.

Brief Pain Inventory (BPI)

The Brief Pain Inventory (BPI) allows patients to rate two dimensions of their pain: the severity of it and the degree to which their pain interferes with common dimensions of feeling and function. The [BPI short form](#) is used for clinical trials and is the version used for the foreign-language translations; the BPI long form contains additional descriptive items that may be clinically useful (for example, items that expand the possible descriptors of pain, such as burning, tingling, etc.).

There is no scoring algorithm, but "worst pain" or the arithmetic mean of the four severity items can be used as measures of pain severity; the arithmetic mean of the seven interference items can be used as a measure of pain interference.

A 30% improvement in pain and function is considered clinically meaningful.

Urine Drug Testing

Urine drug tests can provide information about drug use that is not reported by the patient. Concurrent use of opioid pain medications with other opioid pain medications, benzodiazepines, or heroin can increase patients' risk for overdose. According to New Mexico Medical Board (NMMB) regulation, urine toxicology screens are required before prescribing opioid therapy, and every 6 months while on opioid therapy.

In addition, urine drug tests can assist clinicians in identifying when patients are not taking opioids as prescribed, which may be an indicator of diversion or other clinically important issues such as difficulties with adverse effects. So, consider urine drug testing at least every 6 months to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

The urine drug test does not provide accurate information about how much or what dose of opioids or other drugs a patient took. Furthermore, while a urine drug test can show results for hydrocodone, morphine, codeine, and heroin, the test cannot show results for other opioids: buprenorphine, oxycodone, methadone, and fentanyl. Separate tests are needed to screen for these medications.

Before urine testing:

- Explain that the purpose of the test is for safety. See [Key Messages](#).
- Explain the expected results (i.e., the presence of prescribed medication and the absence of drugs, including illicit drugs not reported by the patient).

- Ask the patient about use of prescribed and other drugs and ask whether there might be unexpected results. Give the patient an opportunity to disclose information about changes in their use of prescribed opioids or other drugs.

When there are unexpected results:

- Discuss them with both the local laboratory/toxicologist and with the patient. Discussion with patient can sometimes yield a candid explanation of why a particular substance is present or absent, and obviate the need for expensive confirmatory testing on that visit (e.g., a patient explains that the test is negative for prescribed opioids because she felt opioids were no longer helping her and discontinued them).
- If unexpected results are not explained, a confirmatory test using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography/mass spectrometry) might be warranted to clarify the situation.
- Consider change in pain management strategy, [tapering](#) or discontinuation of opioids, more frequent re-evaluation, offering [naloxone](#), or referral for treatment for substance use disorder, as appropriate.

Prescription Monitoring Program (PMP)

According to NMMB regulation, a practitioner must review the patient's history of controlled substance prescriptions using New Mexico's prescription monitoring program (PMP) data before prescribing/dispensing a controlled substance (schedule II, III, IV or V) for the first time for period greater than four days, or if there is a gap in prescribing the controlled substance for 30 days or more. The purpose of this review is to determine whether the patient is receiving opioid dosages or dangerous combinations that may put them at high risk for overdose. PMP data should be reviewed before every new opioid prescription.

Upon review of a PMP report for a patient, identify whether the patient currently:

- | | |
|---|--|
| 1. receives opioids from multiple prescribers; | 5. receives opioids totaling greater than 90 morphine milligram equivalents per day; |
| 2. receives opioids and benzodiazepines concurrently; | 6. exhibits potential for abuse or misuse of controlled substances. |
| 3. receives opioids for more than 12 consecutive weeks; | |
| 4. receives more than one controlled substance analgesic; | |

If a patient is found to have high opioid dosages, dangerous combinations of medications, or multiple controlled substance prescriptions written by different clinicians:

- Discuss information from the PMP with the patient:
 - Confirm that the patient is aware of the additional prescriptions. Occasionally, PMP information can be incorrect (e.g., if the wrong name or birthdate has been entered, the patient uses a nickname or maiden name, or another person has used the patient's identity to obtain prescriptions).
 - Discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving opioids from more than one prescriber or receiving medications that increase risk when combined with opioids (e.g., benzodiazepines), and consider offering [naloxone](#).
- Coordinate care:
 - Discuss safety concerns with other clinicians who are prescribing controlled substances for the patient.
 - To avoid prescribing opioids and benzodiazepines concurrently whenever possible, communicate with others managing the patient, and discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure.
- [Calculate the total MME/day](#) for concurrent opioid prescriptions to help assess the patient's overdose risk. If the patient is found to be receiving high total daily dosages of opioids, discuss safety concerns with the patient. Consider [tapering](#) to a safer dosage. Consider offering [naloxone](#).
- Consider the possibility of a substance use disorder, and discuss concerns with the patient.
- If you suspect the patient might be sharing or selling opioids and not taking them, use the results of [urine drug testing](#) to determine whether opioids can be discontinued without causing withdrawal. A negative drug test for prescribed opioids is a likely indicator that the patient is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result.

Document the receipt and review of PMP reports in the patient's medical record.

SOAPP-R

Any time an opioid medication is being considered for an opioid-naïve patient, before it is prescribed, the Screener and Opioid Assessment for People with Pain - Revised (SOAPP-R®) can be effective in identifying factors associated with a patient's risk for misuse of opioid medication. It can predict which patients will require more or less monitoring in long-term opioid therapy. The form contains 24 items and takes under 10 minutes to complete.

COMM

For assessment and treatment monitoring for patients who are already on opioid therapy, the Current Opioid Misuse Measure (COMM®) assessment can be effective in identifying whether the patient may be exhibiting aberrant behaviors associated with opioid medication misuse. The form contains 17 items and takes under 10 minutes to complete.

Evaluating the Risk of Opioid Misuse

Risk	Urine Drug Test	New Mexico PMP Database	SOAPP-R score	COMM score
LOW RISK	Consistent with patient's self-report of current medications	- Prescription history consistent with patient's self-report - Patient obtains prescriptions from a single provider	< 10	< 9
MODERATE RISK	Consistent with patient's self-report of current medications	- Prescription history consistent with patient's self-report - Patient obtains pain medication prescriptions from more than one source	10 to 21	NA
HIGH RISK any ONE of these results:	- Not consistent with the patient's self-report; OR - Indicates drugs of abuse	- Prescription history not consistent with patient's self-report - Patient obtains pain medication prescriptions from more than one source	≥ 22	≥ 9

Benzodiazepines

Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. Benzodiazepines and opioids both cause central nervous system depression and can decrease respiratory drive. Concurrent use may put patients at greater risk for potentially fatal overdose.

To discontinue benzodiazepines, wean by 25% every 1-2 weeks. CBT and/or non-benzo anxiolytics should be used to help with the process.

Documenting Chronic Opioid Therapy

The NMMB recommends the following standard documentation for patients treated with chronic opioid therapy for chronic pain:

- Results of physical exam
- Any previous history of significant pain
- Past history of alternate treatments for pain
- Potential for substance abuse
- Coexisting disease or medical conditions
- Presence of a medical indication or contra-indication against the use of controlled substances
- PMP report is appropriate
- Signed controlled medication agreement is on file

Patients at Risk for Opioid Associated Harms

Risk of harm or overdose is greater for patients with sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders.

Patient Population	Considerations
Sleep-Disordered Breathing, including Sleep Apnea: Opioid medications present the potentially lethal side effect of central respiratory depression.	- Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing. - Closely monitor and use cautious dose titration for patients with mild sleep-disordered breathing.
Pregnant and Breastfeeding Women: Opioids used in pregnancy may be associated with additional risks to both mother and fetus, including stillbirth, poor fetal growth, pre-term delivery, and birth defects. Opioid use during pregnancy may lead to neonatal opioid withdrawal syndrome. Moreover, neonatal toxicity and death have been reported in breastfed infants whose mothers were taking codeine.	- Discuss family planning and how long-term opioid use might affect any future pregnancy. - Consider risks and benefits when prescribing opioids to pregnant women. - Avoid prescribing codeine for mothers who are breast feeding, and, if used, limit codeine to the lowest possible dose and to a 4-day supply.
Renal or Hepatic Insufficiency: The patients have a decreased ability to process and excrete drugs, susceptibility to accumulation of opioids, and reduced therapeutic window between safe dosages and dosages associated with respiratory depression and overdose.	Use additional caution and increased monitoring to minimize risk.
Aged ≥65 Years: Older adults taking opioids are 4 to 5 times more likely to fall than those taking NSAIDs. Also, these patients may have reduced renal function and medication clearance. In addition, some older adults may have cognitive impairment putting them at a higher risk of self-medication errors and a higher risk for overdose. They also may have co-morbid medical conditions, some of which may interact with opioids.	Use additional caution and increased monitoring to reduce risk.
Mental Health Conditions: Psychological distress can interfere with improvement of pain and function in patients with chronic pain. Access to opioid medication may put some suicidal patients at risk for unintentional or intentional overdose. One study found that 54 percent of overdoses from prescription opioids were unintentional, but the rest were either intentional suicide attempts or undetermined. In New Mexico, 80 to 85 percent of drug overdose deaths are unintentional (or undetermined).	- Opioid therapy should not be initiated during acute psychiatric instability or uncontrolled suicide risk. - Consult behavioral health specialist for any patient with a history of suicide attempt or psychiatric disorder. - Confirm that treatment for depression and other mental health conditions are concurrently addressed. - Use additional caution and increased monitoring to mitigate the risk for opioid use disorder among patients with mental health conditions (including depression, anxiety disorders, and PTSD), as well as to mitigate the risk for overdose among patients with depression. - Consult with behavioral health specialists when needed.
Substance Use Disorder (SUD): Patients with drug or alcohol use disorders are likely to experience greater risks for opioid use disorder and overdose than persons without these conditions.	- Consult SUD specialists and pain specialists regarding pain management for persons with active or recent past history of substance abuse. - Communicate with the patient's SUD treatment providers when available if opioids are prescribed.
Prior Nonfatal Overdose: Prior nonfatal overdose may substantially increase risk for future nonfatal or fatal opioid overdose.	- Work with patient to reduce opioid dosage and to discontinue opioids. - If opioid therapy for chronic pain continues, discuss the increased risks for overdose with patients; carefully consider whether benefits of opioids outweigh substantial risks; and incorporate strategies to mitigate risk into the management plan, such as offering naloxone and increasing frequency of monitoring.

Epic has tools (in Doc Flowsheets) for calculating a *Controlled Substance Risk Assessment* and an *Opioid Risk Assessment*.

Preferred Therapies for Chronic Pain

Several non-pharmacologic and non-opioid pharmacologic treatments have been shown to be effective in managing chronic pain in studies ranging in duration from 2 weeks to 6 months. When effective, these therapies are preferred for managing chronic pain.

Condition	<i>Consider the evidence-based therapies:</i>	
	Non-pharmacologic	Pharmacologic (non-opioid)
diabetic neuropathy		anticonvulsants such as pregabalin or gabapentin; duloxetine; tricyclic antidepressants
fibromyalgia	exercise therapy; pool therapy	duloxetine; pregabalin; tricyclics
hip osteoarthritis	exercise therapy; replacement surgery	acetaminophen; NSAIDs
knee osteoarthritis	exercise therapy; physical therapy; weight loss; replacement surgery; acupuncture	acetaminophen; NSAIDs
low back pain	exercise therapy; myofascial therapy	acetaminophen; NSAIDs
musculoskeletal pain		Duloxetine
neuropathic pain, certain conditions		pregabalin, gabapentin, and carbamazepine
osteoarthritis	arthrocentesis; heat; pool therapy	acetaminophen; NSAIDs; intraarticular glucocorticoid injection
post-herpetic neuralgia		anticonvulsants such as pregabalin or gabapentin; tricyclic antidepressants; SNRIs
rheumatoid arthritis	arthrocentesis; heat; tai chi	acetaminophen; NSAIDs; intraarticular glucocorticoid injection
rotator cuff disease	physical therapy; surgery	subacromial corticosteroid injection

Non-pharmacologic Therapy

Specific non-pharmacologic physical and psychological treatments are approaches that encourage active patient participation in the care plan, address the effects of pain in the patient's life, and can result in sustained improvements in pain and function without apparent risks:

- Cognitive behavioral therapy (CBT) trains patients in behavioral techniques and helps patients to modify situational factors and cognitive processes that exacerbate pain. It can also have small positive effects on disability and catastrophic thinking.
- Exercise therapy can help reduce pain and improve function in chronic low back pain, improve function and reduce pain in osteoarthritis of the knee and hip, and improve well-being, fibromyalgia symptoms, and physical function in fibromyalgia
- Interventional approaches, such as epidural injection for certain conditions (e.g., lumbar radiculopathy), can provide short-term improvement in pain.

Multimodal therapies and multidisciplinary therapies (e.g., therapies that combine exercise and related therapies with psychologically based approaches) can reduce long-term pain and improve function more effectively than single modalities (e.g., exercise alone). Multimodal therapies should be considered for patients not responding to single-modality therapy, and combinations should be tailored depending on patient needs, cost, and convenience.

Non-opioid Pharmacologic Therapy

Several non-opioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) can be effective for chronic pain.

The CDC has [recommended non-opioid medications for chronic pain](#). Clinicians should review FDA-approved labeling including boxed warnings before initiating treatment with any pharmacologic therapy.

Opioid Therapy

Clinicians should consider opioid therapy for chronic pain only if they anticipate that the benefits for both pain and function outweigh risks to the patient. If opioids are used, they should be combined with [non-pharmacologic therapy](#) and [non-opioid pharmacologic therapy](#), as appropriate.

Clinical Tracking System

Tools within the electronic health record (Epic EHR) enable the management of prescribed controlled substances:

- **Controlled Substance Care Plan (CSCP):** the central place to document prescribed controlled substances; it conveys the patient's history to providers across the system. Add code CSCP to the problem list.
- **Controlled Substance Flow Sheet:** for documenting the [Controlled Medication Treatment Agreement](#), violations, and details; also, there are assessment tools for quantifying the risk of harm or misuse. This flowsheet can be saved to favorites.
- **Controlled Substance Snapshot:** this dashboard view pulls together the patient's details from the Controlled Substance Flow Sheet, the patient's medications, problem list, recent appointments, risk assessment score, and results from urine drug screens. To access it, search for it in the snapshot report field; it can be saved to default settings.

Shared Decision Making

Clinicians should involve patients in decisions about whether to start or continue opioid therapy. Given potentially serious risks of long-term opioid therapy, clinicians should explain and document the potential risks and benefits of opioids, along with alternatives, before starting or continuing opioid therapy. See [Key Messages](#) for patient.

Consider whether a patient's cognitive limitations might interfere with management of opioid therapy (for older adults in particular) and, if so, determine whether a caregiver can responsibly co-manage medication therapy.

Set Goals

The CDC suggests that, before starting opioid therapy for the opioid-naïve patient, clinicians establish treatment goals with all patients, including realistic goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Controlled Medication Treatment Agreement

According to NMMB regulation ([16.10.14.9 NMAC](#)), the chronic pain patient and the prescribing practitioner enter into a [written agreement](#) that outlines the patient's responsibilities when taking a prescribed controlled substance for pain therapy.

The Provider as well as the RN team nurse should review the written agreement and its responsibilities with the patient. The signed agreement is scanned and entered in to the patient's medical record.

Prescribing Opioids Initially

When starting opioid therapy for chronic pain:

- Prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (See [Medications](#), page 18.)
- Prescribe the lowest effective dosage.

Evidence shows that:

- Opioid-related overdose risk is dose-dependent, with higher opioid dosages associated with increased risk of overdose.
- Patients can experience tolerance and loss of effectiveness of opioids over time.
- Patients who do not experience clinically meaningful pain relief early in treatment (i.e., within 1 month) are unlikely to experience pain relief with longer-term use.

Use additional caution when initiating opioids for patients aged ≥ 65 years and patients with renal or hepatic insufficiency because decreased clearance of drugs, which is more common with these patients, can result in accumulation of drugs to toxic levels.

Schedule a follow up appointment to evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain. Consider follow-up intervals within the lower end of this range when: 1) ER/LA opioids are started or increased; or 2) total daily opioid dosage is ≥ 50 MME/day. Even shorter follow-up intervals (within 3 days) should be strongly considered when starting or increasing a dosage of methadone.

Calculating MME

Calculating the total daily dose of opioids using the morphine milligram equivalent (MME) can identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose. To calculate the total daily dose of opioids:

1. Determine the total daily amount of each opioid the patient takes (from all sources).
2. Calculate each amount in MME by multiplying each amount by the conversion factor (see table).
3. Find the sum of all MMEs.

CDC guidelines recommend keeping doses to less than 50 MME/day. For example, 50 MME/day equals:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

OPIOID (doses in mg/day except where noted)	MME CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)*	2.4
Hydrocodone	1
Hydromorphone	4
Methadone:**	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61 -80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

**Fentanyl transdermal patches are dosed in mcg/hr instead of mg/day. Absorption is affected by heat and other factors.*
***The conversion factor for methadone increases at higher doses.*

Do not use this calculation method to determine the dose of methadone to prescribe. Doing so can result in dosages of methadone that surpass a patient's tolerance, and can increase the risk of accidental lethal overdose. Treatment with methadone should only be attempted by prescribers with experience using it, or in consultation with prescribers with experience using it.

Naloxone

Naloxone is an opioid antagonist that can reverse severe respiratory depression and can be administered by lay persons.

Naloxone precipitates acute withdrawal among patients physically dependent on opioids. Serious adverse effects, such as pulmonary edema, cardiovascular instability, and seizures, have been reported but are rare at doses consistent with labeled use for opioid overdose.

Consider offering naloxone when prescribing opioids to patients at increased risk for overdose, including patients:

- With a history of overdose
- With a history of substance use disorder
- Taking benzodiazepines with opioids
- Taking higher dosages of opioids (≥ 50 MME/day)
- At risk for returning to a high dose to which they are no longer tolerant (e.g., patients recently released from prison)

Provide education on overdose prevention and naloxone use to patients receiving naloxone prescriptions and to members of their households. Helpful patient education materials may be found at [Prescribe to Prevent](#).

Ongoing Opioid Use

Continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

At follow up:

- Assess benefits in function, pain control, and quality of life;
- Ask patients about common adverse effects such as constipation and drowsiness;
- Ask about and assess for effects that may be early warning signs for more serious problems such as overdose (e.g., sedation or slurred speech) or opioid use disorder (e.g., craving, wanting to take opioids in greater quantities or more frequently than prescribed, or difficulty controlling use);
- Ask patients about their preferences for continuing opioids given their effects on pain and function relative to any adverse effects experienced.

Long-acting Opioid Medication

There can be increased risks associated with ER/LA opioids. The indication for this class of medications is for management of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment in patients for whom other treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or otherwise inadequate to provide sufficient management of pain.

Consider ER/LA opioids only for a patient who has received immediate-release opioids daily for at least 1 week. For longer-term maintenance, consider transition to long-acting opioid medication with scheduled dosing (not PRN) if:

1. Pain is moderate to severe and constant or nearly constant; or
2. Pain is not adequately relieved by short-acting opioids, or dosage of short-acting opioids is approaching peak levels; or
3. The patient is experiencing withdrawal symptoms as the short-acting opioid medication wears off.

Increasing Dosage

Increase opioid dosages by the smallest practical amount.

When considering increasing dosage to ≥ 50 MME/day, carefully reassess evidence of individual benefits and risks.

If the patient's opioid dosage for all sources of opioids combined reaches or exceeds 50 MME/day, implement additional precautions:

- Increase the frequency of follow-up.
- Consider offering [naloxone](#) and overdose prevention education to everyone in the patients' household.

Avoid increasing dosage to ≥ 90 MME/day, or carefully justify and document a decision to titrate dosage to ≥ 90 MME/day.

If patients do not experience improvement in pain and function at ≥ 90 MME/day, or if there are escalating dosage requirements, discuss with the patient other approaches to pain management; consider tapering to a lower dosage, rotating to another opioid, or tapering and discontinuing opioids. Consider consulting a pain specialist.

Given the possibility that benefits of opioid therapy may diminish or that risks may amplify over time, clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, at least every 3 months.

Precautionary Monitoring

Use precautions to reduce risks, including:

PMP

According to NMMB regulation, review the patient's history of controlled substance prescriptions using New Mexico's PMP data a minimum of once **every three months** during the continuous use of a controlled substance (schedule II, III, IV or V). The purpose of this review is to determine whether the patient is receiving opioid dosages or combinations that may put them at increased risk for overdose.

urine drug testing

According to NMMB regulation, urine toxicology screens must be obtained **every six months** during continuous opioid therapy.

Reasons to Suspect Misuse

Certain symptoms or behaviors may alert the Provider that the patient is misusing an opioid medication. These symptoms or behaviors may indicate that the opioid prescription should be tapered or stopped.

Signs and Symptoms:

- Appears sedated, confused, intoxicated, or exhibits withdrawal symptoms.
- Shows signs of skin tracks or scars.
- Suffers overdose or frequent injuries and accidents.

Behaviors:

- Alters, forges, or rewrites prescriptions.
- Implies or makes direct threats to the prescriber or staff.
- Refuses to sign Controlled Medication Agreement or is non-compliant with the Agreement.
- Repeatedly seeks medications from the ED.
- Requests more frequent refills and with a sense of urgency. May claim that their medications were "lost."
- Resists changes in therapy despite clear evidence of adverse effects.

Results/Reports:

- PMP report showing evidence of "doctor shopping" or use of multiple pharmacies to acquire controlled substance prescriptions.
- Urine drug screens that are inconsistent with prescribed medications or show use of substances that may cause respiratory depression.
- Any report of diversion activities.

Managing Side Effects

Some prevention/management strategies for mitigating the side effects of opioids are:

Side Effect	Prevention / Management notes
respiratory depression	<i>Most serious.</i> Screen for sleep apnea and avoid opioids if moderate-to-severe sleep apnea is present. Avoid prescribing opioids to patients who are also using sedatives, hypnotics, benzodiazepines, and/or barbiturates when possible. Avoid prescribing opioids to patients who are engaging in "risky drinking" of alcohol (greater than 5 daily drinks for men/4 daily drinks for women). Educate and prescribe naloxone .
constipation	<i>Common.</i> Educate patients to increase fiber and fluids; start with a mild peristaltic stimulant (senna, dried plums, polyethylene glycol 3350) with a stool softener; increase dose if no BM in 48 hours. Second-line, more expensive medications include a new category of constipation medications for opioid-induced constipation (naloxegol, lubiprostone, linaclotide). Despite availability, they are not considered first-line.
nausea or vomiting	<i>Common.</i> Consider prophylactic antiemetic therapy. Ondansetron (Zofran) is recommended because it does not interact with opioids. Use caution when prescribing ondansetron with drugs that cause serotonergic effects such as tramadol and tapentadol.
itching	<i>Common.</i> Reduce dose and increase frequency, change opioid, and/or consider a non-sedating antihistamine (e.g., cetirizine).
cognitive effects (such as sedation, confusion)	Reduce dose and/or change opioid; avoid sedatives.
perceptual effects (e.g., hallucinations, depression)	Rule out other causes, and eliminate all nonessential CNS-acting medications (e.g., steroids). Reduce opioid dose, or switch opioid.
sexual dysfunction	Rule out other causes. Reduce dose.

Side Effect	Prevention / Management notes
serotonin syndrome	Avoid combining opioids (particularly tramadol) with medications that increase serotonin. (See box below.)
hyperalgesia	Hyperalgesia, the result of a dysfunction of the nociceptive system, results in peripheral and/or central sensitization. Symptoms include widespread pain not consistent with physical findings and/or pain out of proportion to mild stimuli. Animal studies note a lower pain threshold after exposure to sustained opioids. Reduce the dose, taper the patient off opioid medication, or rotate the opioid.

Refills

According to PMG policy, a provider visit may be required to refill a patient's prescription for a controlled substance. Visits are warranted when:

- there is a need to change dosage or medication.
- unexpected results (within the last 4 months) come from a PMP report or urine drug screen.
- routine follow up (a pain and function assessment) is due.
- aberrant behavior is observed.

See [algorithm](#) on page 6.

Morphine Equivalent Dose

CMS developed a comprehensive morphine equivalent dose (MED) approach to assist Part D sponsors in identifying high risk beneficiaries. CMS' implementation of the overutilization monitoring system (OMS) has led to significant reductions in the overuse of opioids in the Part D program.

PHS' opioid prescribing protocols are in accord with CMS' MED regulations:

- When the MED is less than 120 mg, no changes are necessary.
- When the MED is 120 mg to 199 mg, the dispensing pharmacist will consult the prescriber before approval.
- When the MED is 200 mg or greater, the prescriber will submit a prior authorization (PA) for review by the health plan.
- For patients age ≥65 years old, [tapering](#) is advised.

Note: CDC's terminology morphine milligram equivalents ([MME](#)) is equal to morphine equivalent dose (MED) in milligrams as used by CMS. Often calculated as a daily dose.

Established Patients

Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians, should be offered the opportunity to re-evaluate their continued use of opioids. See [Key Messages](#) for patient.

Breakthrough Pain

Evidence does not support the use of immediate-release opioids for breakthrough pain when ER/LA opioids are used for chronic pain. This practice might be associated with dose escalation. In general, avoid medication therapy for breakthrough pain. Make breakthrough medications available only during a period of [opioid rotation](#), as needed, and then discontinue. A rescue dose in a very small quantity (5%-15% of the total daily dose) of the new medication may be used in an opioid rotation.

Rotation

Rotation is a strategy in which one opioid medication is switched out for another, in an effort to improve therapeutic response or reduce undesirable effects. Rotating medication can help to avoid dose escalation. Opioid rotation may be considered when there is an apparent loss of analgesic effect for the current opioid.

To rotating the patient's opioid medication, use the equianalgesic dose (the opioid dose that produces an equal degree of analgesia) to plan the dosage of the new medication. Identify the lowest therapeutic dose of the new medication, and plan the transition:

1. Calculate the patient's current 24-hour opioid dose (including both short- and long-acting medications).

2. Convert the dose to its morphine milligram equivalent using the [table](#) on page 13.
3. Determine the dosing interval by the formulation used (short-acting vs. long-acting).
4. Reduce the calculated dose of the new medication by approximately 25% to 50%.
5. Determine the equivalency of the new medicine based on the reduced dose.
6. Reassess the strategy in 3 to 5 days.

For example, a patient's current prescription of oxycontin is 60mg TID, and it is showing less analgesic effect for the patient. Rather than increasing the dose, the Provider decides to rotate it with morphine. For the current dose, the 24-hour opioid dose is: 180 oxy/24 h. The morphine milligram equivalent is calculated: $180\text{mg oxy} \times 1.5 = 270\text{mg morphine}$. That product is reduced by 50%: 135 mg/24 h. So the new dose of morphine sulfate to be prescribed is 45mg TID.

Tapering

Taper opioid medication slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection).

Tapering plans may be individualized based on patient goals and concerns:

- A decrease of 10% of the original dose per week is a reasonable starting point, though reducing weekly dosage by 10%–50% of the original dosage may be considered.
- Consider a rapid taper over 2–3 weeks in circumstances of patient safety (e.g., a patient who has experienced overdose on their current dosage).
- Patients who have been taking opioids for years may respond better to slow opioid tapers – slower than 10% per week (e.g., 10% per month) – as well as pauses in the taper to allow gradual accommodation to lower opioid dosages.
- Tapers may be paused and restarted again when the patient is ready, and may be slowed once the patient reaches low dosages.

Watch for signs of anxiety, depression, and opioid use disorder that might be unmasked by an opioid taper, and manage these co-morbidities. Maximize pain treatment with non-pharmacologic and non-opioid pharmacologic treatments, as appropriate. Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day.

Tapers may be considered successful as long as the patient is making progress.

Opioid Withdrawal

Symptoms of opioid withdrawal can occur any time a long-term prescription is curtailed or stopped. Symptoms can start any time after 6 – 30 hours of stopping opioids, depending on the dose and type of opioid. Signs of withdrawal include:

- | | |
|--|--------------------------------------|
| • Agitation, anxiety, and / or insomnia | • Abdominal cramps and / or diarrhea |
| • Muscle cramps, runny nose, sweating, yawning, tearing, goose bumps | • Nausea and / or vomiting |
| | • Dilated pupils |

Opioid withdrawal is not typically life threatening, with two exceptions: 1) pregnancy, and 2) unstable cardiac disease.

Medications

For all medications, begin with the lowest possible dose. Maximum dosing: The maximum dose for all medications should not exceed 90 morphine milligram equivalents (MMEs) per day. (See page 13 for [MME conversion table](#) and additional cautions.) Abuse-deterrent formulations may be more expensive; some long-acting opioids may require step therapy.

Class	Drug	PHP Formulary	Cost*	Lowest possible / usual Starting Dose	50 MME Dose	90 MME Dose
SHORT-ACTING (Oral Dose) Opioid Medications	hydrocodone Used in combination with: •APAP (Norco, Vicodin) •Ibuprofen (Vicoprofen)	Centennial Care: QL Commercial: T1, QL Metal Level: T2, QL Senior Care/Medicare: T2, QL <i>Note: Hydrocodone-apap only covered on the formularies.</i> <i>Notes: Special populations. Use with caution, and start at low end of initial dose range in elderly/frail patients. Renal or hepatic impairment. Use lower initial dose for moderate impairment, and an even lower initial dose for severe impairment; use with caution, and monitor closely for respiratory and CNS depression.</i>	\$74.00	5 mg every 6 hours	50 mg/day	90 mg/day
	hydromorphone (Dilaudid)	Centennial Care: QL Commercial: T1, QL Metal Level: T2, QL Senior Care/Medicare: T2, QL <i>Notes: Special populations. Use with caution in elderly or debilitated patients. Risk of accumulation due to decreased clearance in patients with renal impairment. Renal or hepatic impairment. Use lower initial dose for moderate impairment, and an even lower initial dose for severe impairment; use with caution, and monitor closely for respiratory and CNS depression.</i>	\$42.00	2 mg every 6 hours	12 mg/day	22 mg/day
	morphine (MSIR)	Centennial Care: QL Commercial/Metal Level 2017: T1, QL Metal Level 2018: T2, QL Senior Care/Medicare: T3, QL <i>Notes: Special populations. Use with caution and reduce dose in elderly or debilitated patients. In renal impairment, avoid or start cautiously with lower doses, titrate more slowly, and carefully monitor for side effects, which may be delayed.</i>	\$240.00	15 mg every 4 to 6 hours (usually not used as first line oral therapy)	50 mg/day	90 mg/day
	oxycodone IR Used in combination with: •APAP (Percocet) •Aspirin (Roxiprin) •Ibuprofen (Roxicodone)	Centennial Care: QL Commercial: T1, QL Metal Level: T2, QL Senior Care/Medicare: T2, QL <i>Note: Oxycodone and oxycodone-apap only covered on the formularies.</i> <i>Notes: Special populations. Reduce dose for elderly or debilitated patients. For oxycodone (alone). Initiate at the lowest dosage. Renal or hepatic impairment. Use with caution. In hepatic impairment initiate at 33% to 50% of the usual dosage and titrate carefully.</i>	\$51.00	5 mg every 6 to 8 hours	33 mg/day	60 mg/day
	oxymorphone (Opana IR)	Centennial Care: NF Commercial: NF (Commercial), T3, ST, QL (Metal Level 2017) Metal Level 2018: T4, ST, QL Senior Care/Medicare: NF <i>Notes: Instruct patients not to consume alcoholic beverages or use prescription or nonprescription products that contain alcohol while taking oxymorphone.</i>	\$296.00	5 mg every 6 hours	17 mg/day	30 mg/day
	tapentadol (Nucynta)	Centennial Care: NF Commercial: NF Metal Level: NF Senior Care/Medicare: NF <i>Notes: Renal impairment. Not recommended in patients with CrCl < 30 mL / minute. Hepatic impairment. Not recommended in severe impairment (Child – Pugh Class C). Helpful for patients prone to nausea and vomiting with other opioids. Prescribe with caution in patients taking SSRIs or tricyclic antidepressants.</i>	\$864.00	50 mg every 6 hours	See CDC guidelines and/or CMS guidelines for conversion information.	
	tramadol Used in combination with: •acetaminophen/APAP (Ultracet)	Centennial Care: QL, AG Commercial: T1, QL, AG Metal Level: T2, QL, AG Senior Care/Medicare: T2, QL <i>Note: Tramadol only covered on the formularies.</i>	\$83.00	50 mg every 6 hours	See CDC guidelines and/or CMS guidelines for conversion information.	

•Alone (Ultram)

*Notes: **Special populations.** For elderly patients, do not exceed 300 mg / daily in divided doses; initiate at lowest dose possible. Use with caution in debilitated patients due to greater risk for respiratory depression, even at therapeutic doses. For patients with renal dysfunction, use 12-hour dosing, and do not exceed 200 mg / day.
Tramadol can increase seizure risk, especially in patients taking SSRIs, tricyclics, MAOIs, neuroleptics, or other drugs that decrease seizure threshold in patients with epilepsy or seizure risk; in those taking > 400 mg / day.
Poses higher risk of serotonin syndrome than other opioids.*

F=Formulary NF=Non-Formulary T=Tier PA=Prior Authorization QL=Quantity Limit ST=Step Edit AG= Age Limit

*Costs are estimates based on generic cost in Medispan, a 30-day supply at the recommended starting dosage, and are subject to change.

All Schedule II narcotic medications are limited to a 30-day supply per prescription fill.

Class	Drug	PHP Formulary	Cost*	Notes	50 MME Dose	90 MME Dose
LONG-ACTING Opioid Medications	buprenorphine transdermal system (Butrans)	Centennial Care: NF Commercial/Metal Level: NF Senior Care/Medicare: NF	\$224.00	Dosing. May be used in opioid-naïve patients at initial dose of 5 mcg / hr. Doses exceeding the maximum of 20 mcg / hr have shown QT prolongation in clinical trials. Titration. Should occur on an individualized basis. Wait at least 3 days before increasing dose of buprenorphine. Conversion. Buprenorphine conversion has the potential to precipitate withdrawal in patients who are already on opioids. Before conversion, taper total daily dose for up to 7 days to no more than 30 mg per day morphine (or equianalgesic dose). Application. If adhesion is an issue, patch edges may be taped with first aid tape. Avoid external heat sources on application site.	See CMS guidelines for conversion information.	
	buprenorphine buccal (Belbuca)	Centennial Care: NF Commercial: NF Metal Level: NF Senior Care/Medicare: NF	\$398.00	Titration. Taper current opioid to no more than 30 mg oral MME daily before initiating. Base initial dose on daily opioid dose prior to taper; additional short- acting analgesics may be needed during taper. Titrate in increments of 150 mcg every 12 hours, no more frequently than every 4 days; additional short-acting analgesics may be needed during titration. Special populations. Use reduced dose in elderly or debilitated patients. Use with caution in renal impairment. For moderate hepatic impairment (Child-Pugh Class C), use with caution and monitor carefully. For severe hepatic impairment, reduce starting dose and reduce titration dose by 50 %. Administration. Educate patient not to chew, swallow, touch, or move film after placement. Liquids and food can be consumed after film dissolves. Film should not be cut or torn. Avoid applying to areas of the mouth with any open sores or lesions.	See CMS guidelines for conversion information.	
	fentanyl transdermal system (Duragesic)	Centennial Care: ST, QL Commercial: T1, QL Metal Level: T2, QL Senior Care/Medicare: T2, QL	\$148	Dosing. Use only in opioid-tolerant patients who have been taking > 60 mg / day morphine (or equianalgesic dose) for at least 1 week. Titration: Base increments on supplemental opioid doses with ratio of 25 mcg / hr fentanyl for every 90 mg / day of morphine equivalent. Wait at least 3 days after starting dose, then increase no more often than every 6 days. Half-life continues 17 hours after removal; steady state is reached after two 72-hour applications. Special populations. Use with caution in elderly or frail patients. Use caution in hepatic or renal dysfunction. Reduce dose and monitor for adverse effects in patients with fever. Helpful for patients prone to constipation, with GI absorption problems, or intestinal resection. Application. Avoid external heat sources on application site. Use Tegaderm over the patch to help fix it in place.	See CMS guidelines for conversion information. Fentanyl is provided in multiple dosage forms and absorption / bioavailability vary.	
	Hydrocodone ER (Hysingla ER, Zohydro ER)	Centennial Care: NF Commercial: NF Metal Level: NF Senior Care/Medicare:	\$340.00 to \$666.00	Dosing. Discontinue all other, around-the-clock opioids when hydrocodone ER is initiated. Titration. May increase Hysingla ER by 10 to 20 mg every 3 to 5 days and Zohydro ER by 10 mg every 12 hours every 3 to 7 days. Conversion. When converting from other oral hydrocodone formulations, initiate Hysingla ER at the same total daily dose once daily; initiate Zohydro ER at the same total daily dose, divided in half, as equal doses every 12 hours. When converting from other opioids, consult prescribing information for guidance. Special populations. In renal impairment, monitor closely. Initiate Zohydro ER at a low dose. In moderate-to-severe impairment or end-stage renal disease, start with 50 % of the initial Hysingla ER dose. In severe hepatic impairment, monitor closely. Initiate Zohydro ER 10 mg every 12 hours; initiate Hysingla ER at 50 % of the initial dose.	50 mg/day	90 mg/day

hydromorphone ER (Exalgo)	Centennial Care: NF Commercial: NF Metal Level: T4, ST, QL Senior Care/Medicare: NF	\$222.00	Dosing. For opioid-tolerant patients only. Only prescribe after discontinuation of all other extended-release opioids and around-the-clock opioids. Titration. May increase by 4 mg to 8 mg every 3 to 4 days as needed. Conversion. When converting from hydromorphone immediate release, initiate at the same total daily dose every 24 hours. When converting from other opioids, consult prescribing information for guidance. Special populations. Reduce initial dose in elderly / frail patients. Avoid in severe hepatic impairment. In moderate impairment, initiate with 25 % of the usual starting dose. In severe renal impairment, initiate with 25 % of the usual starting dose and 50 % of the starting dose in moderate impairment.	12 mg/day	22 mg/day
methadone	Centennial Care: PA, QL Commercial: T1, QL Metal Level: T2, QL Senior Care/Medicare: T2, QL	\$23.00	Dosing. Mismatch of long half-life with shorter duration of analgesia can be life-threatening. Methadone should only be prescribed by experienced providers who are both familiar with its risks and appropriate use and prepared to conduct necessary and careful monitoring. Special populations. Use caution with elderly or debilitated patients; reduce dosage and consider inpatient monitoring during initial titration. Avoid in patients with cardiac conditions and/or patients using medications that can prolong QT interval. Avoid in patients with sleep-disordered breathing.	See CDC Guidelines for conversion information; there are four different conversion factors for this medication.	
morphine •ER (Avinza Kadian) capsules; (MS Contin) tablet •In combination w/ naltrexone core (Embeda)	Centennial Care: F, QL (MS Contin) ST, QL (Avinza, Kadian), Commercial: T1, QL (MS Contin) T3, ST, QL (Avinza, Kadian) Metal Level: T2, QL (MS Contin) T4, ST, QL (Avinza, Kadian) Senior Care/Medicare: T2, QL (MS Contin), NF (Avinza, Kadian) Note: Embeda is NF on all plans.	\$110.00 (MS Contin) to \$170.00	Titration. For Avinza, increase by as much as 30 mg daily, every 3 to 4 days; adjust Kadian, MS Contin, or Embeda every 1 to 2 days. Conversion. When converting from morphine immediate release, initiate at the same total daily dose: For Avinza, every 24 hours; for Kadian, once daily or in 2 divided doses every 12 hours; for MS Contin, in 2 divided doses every 12 hours or in 3 divided doses every 8 hours. When converting from other opioids, consult prescribing information for guidance. Special populations. Use caution with elderly or debilitated patients. Dose adjustment may be necessary in moderate to severe hepatic impairment and cirrhosis. In renal impairment, avoid or start cautiously with lower doses, titrate more slowly, and carefully monitor for side effects that may be delayed. Administration. CR tablets must be swallowed whole. Kadian and Avinza capsules can be opened and sprinkled on applesauce and eaten immediately without chewing. Ensure all pellets have been swallowed by rinsing mouth.	50 mg/day	90 mg/day
oxycodone ER •(Oxycontin) tablet •(Xtampza) capsule	Centennial Care: NF Commercial: NF Metal Level: NF Senior Care/Medicare: NF	\$213 to \$320.40	Titration: Adjust in increments (tablets 25 %, capsules 25 % to 50 %) no more frequently than every 1 to 2 days; rescue medications may be needed during titration. Special populations. In renal or hepatic impairment, initiate at 33 % to 55 % of the calculated recommended dose; consider alternative if dose is less than the smallest available dosage form. Administration. Tablets must be swallowed whole. Capsules be opened and the contents sprinkled on soft foods or into a cup for administration directly into the mouth. Ensure all pellets have been swallowed by rinsing mouth.	33 mg/day	60 mg/day
oxymorphone (Opana ER)	Centennial Care: ST, QL Commercial: T3, ST, QL Metal Level: T4, ST, QL Senior Care/Medicare: T4, ST, QL	\$150.00	Titration. Increase by increments of 5 – 10 mg every 12 hours, every 3 to 7 days. Special populations. Use caution and reduce dosage with elderly patients. Avoid in hepatic dysfunction. For renal impairment, start at the lowest dose and titrate slowly while monitoring side effects. Administration. Administer on an empty stomach; must be swallowed whole.	17 mg/day	30 mg/day
tapentadol ER (Nucynta ER)	Centennial Care: NF Commercial: NF Metal Level: T4, PA, QL Senior Care/Medicare: NF	\$450.00	Dosing. Discontinue all other around-the-clock opioids when tapentadol ER is initiated. In opioid-tolerant patients⁵, begin with a dose that is 50 % of the estimated daily tapentadol requirement; use 2 equal doses every 12 hours with immediate-release medications to supplement (if needed). Titration. Titrate in increments of 50 mg no more frequently than twice daily every 3 days. Conversion. When converting from tapentadol immediate release,	See CDC guidelines and / or CMS guidelines for conversion information.	

				initiate at the same total daily dose, divided in half, as equal doses every 12 hours. Special populations. For renal impairment, not recommended in patients with CrCl < 30 mL / minute. For moderate hepatic impairment (Child-Pugh Class B), start with an initial dose of 50 mg every 24 hours or longer with a maximum of 100 mg once daily. Use is not recommended in severe impairment (Child-Pugh Class C).	
	tramadol ER (Ultram ER)	Centennial Care: NF Commercial: T3, QL, AG Metal Level: T4, QL, AG Senior Care/Medicare: T2, QL	\$112.00	Dosing. Tramadol can increase seizure risk, especially in patients taking SSRIs, tricyclic antidepressants, MAOIs, neuroleptics, or other drugs that decrease seizure threshold and in patients with epilepsy or seizure risk factors. Special populations. Start at low end of dosing range, and use the lowest effective dose in elderly patients. Use with caution in mild or moderate renal or hepatic impairment. Avoid in severe renal or hepatic impairment.	See CMS guidelines for conversion information.

F=Formulary NF=Non-Formulary T=Tier PA=Prior Authorization QL=Quantity Limit ST=Step Edit

*Costs are estimates based on generic cost in Medispan, a 30-day supply at the recommended starting dosage, and are subject to change.

All Schedule II narcotic medications are limited to a 30 day supply per prescription fill.

Class	Drug	PHP Formulary	Cost*	Notes
Opioid Antagonist Medication	Naloxone HCL (Narcan)	Centennial Care: F Commercial: T2 Metal Level: T3 Senior Care/Medicare: T3	\$75.00/dose	Administer a single spray intranasally into one nostril. Seek emergency medical care immediately after use. Additional doses may be given, using a new nasal spray with each dose, every 2 to 3 minutes until emergency medical assistance arrives if the patient does not respond or responds and then relapses into respiratory depression after the initial dose is given. Narcan nasal spray is indicated for the emergency treatment of known or suspected opioid overdose. The CDC recommends that clinicians consider offering naloxone to patients prescribed opiates when factors that increase the risk for opioid overdose are present (e.g., history of overdose, history of substance use disorder, opioid dosages ≥ 50 MME/day, or concurrent benzodiazepine use).

Measurement and Reporting

Opioid medication use among PMG primary care empaneled patients is monitored as the number of unique (monthly) prescriptions written over a 12-month period. Goals for reducing the number of opioid prescriptions are being pursued as part of an enterprise-wide opioid stewardship effort.

Patient Education and Support

Patient Education	
Patient Goal	Key Messages for the Patient
Understand pain management.	- Improvement in function is a primary goal, and function can improve even when pain is still present. - For optimal pain management and continued care, make an effort to remain in the care of one primary health care provider.
Understand opioid medication.	- While opioids can reduce pain during short term use, there is no reliable evidence that opioids improve pain or function with long-term use, and complete relief of pain is unlikely. - Serious adverse effects of opioids: - increased risk of death due to respiratory depression (slowed breathing) - potential for developing a serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations - Other side effects of opioids: - constipation, dry mouth, nausea, vomiting, poor appetite, itching, drowsiness/sleepiness/sluggishness, confusion, bad dreams, hallucinations, agitation, depression, seizures, tolerance, physical dependence, allergies, immune system changes, decreased sex drive, increased sensitivity to pain, drug interactions, and withdrawal symptoms when stopping opioids - If you are already taking opioids at high dosages (≥ 90 MME/day), evidence shows that you are at risk for overdose. Your provider can review the benefits and risks of continued high-dosage opioid therapy, and work with you to taper your opioid medication to safer dosages or to find non-opioid therapies that are effective and safer. - Your provider takes certain safety precautions when prescribing opioids: - Urine drug testing screens for opioids and other drugs and is intended to improve your safety. - New Mexico's Prescription Monitoring Program has a database that your provider can check to see certain medication prescriptions you obtained from other providers. - PMG follows these and other specific protocols and tracks every patient taking medications that are considered controlled substances. - Know the procedure for refilling your prescription.
Take medication as prescribed.	- If you take opioid medication other (more) than prescribed, there is increased risk of opioid use disorder, respiratory depression, and death due to overdose. - Never change or stop taking any opioid medication without checking with your health care provider first. - If you stop taking opioids suddenly, you may have withdrawal symptoms. If your provider asks you to slowly decrease your use of opioids, follow the provider's instructions. A slow decrease often helps to reduce withdrawal symptoms and to prevent you from feeling sick.
Make key lifestyle changes.	- Opioids might affect your ability to safely operate a vehicle. - Don't drink alcohol or take illegal drugs. They can impair your ability to manage your opioid therapy and cause severe harm or death. - Others in your household are at risk. If you share opioids (intentionally or unintentionally) with others, they might experience overdose. So: - Opioids should be stored in a secure, preferably a locked location. - Know your options for safe disposal of unused opioids.
Keep your appointments.	Periodic reassessment is important to ensure that opioids are helping to meet your goals and to allow your provider to consider of additional non-opioid treatment options that might be more effective.
Communicate with your provider.	- There needs to be trust, honesty, and good communication between you and your health care provider. - Tell your health care provider about all medications and supplements that you currently take. - Be honest and thorough when you report your health, drug, and alcohol history. - Inform all of your providers that you are currently prescribed opioids. - Tell your primary health care provider (within 24 hours) if another provider prescribes an opioid for you. - If you think you are having withdrawal symptoms, tell your provider. Your provider may be able to give you medication for a short time to help control them.

Clinical Definitions

chronic pain	Pain that typically lasts >3 months or past the time of normal tissue healing. Chronic pain consists of both persistent pain, which is pain that is continuous throughout the day, and breakthrough pain (BTP), which involves transitory flares of moderate-to-severe pain in a person whose persistent pain is otherwise controlled. Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause. Estimates of the prevalence of chronic pain vary; an estimated 14.6% of U.S. adults have current widespread or localized pain lasting at least 3 months. Chronic pain is often due to musculoskeletal pain conditions (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches). It can be complicated by psychological comorbidities and a range of contributing factors, and can have a range of effects on daily functioning.
cognitive behavioral therapy (CBT)	Cognitive behavioral therapy (CBT) is a form of psychotherapy that treats problems and boosts happiness by modifying dysfunctional emotions, behaviors, and thoughts. CBT focuses on solutions, encouraging patients to challenge distorted cognitions, and change destructive patterns of behavior. CBT can address psychosocial contributors to pain and improve function.
controlled medication treatment agreement	This written agreement, signed by the patient, outlines the patient's responsibilities when taking a prescribed controlled substance for pain therapy.
controlled substance care plan (CSCP)	The CSCP is a tool within the Epic environment, a central place to document prescribed controlled substances; it conveys the patient's history to providers across the system. Add code CSCP to the problem list.
extended-release / long-acting (ER/LA) opioids	ER/LA opioids include methadone, transdermal fentanyl, and extended-release versions of opioids such as oxycodone, oxymorphone, hydrocodone, and morphine. Evidence shows that there is a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids.
morphine milligram equivalents (MME)	Established by the CDC, a value assigned to a dose of opioid medicine to represent its relative potency. The MME of a dose of an opioid is determined by multiplying it by its equivalency factor. The Centers for Medicare & Medicaid Services (CMS) have published a table of MME conversion factors. MME is equal to morphine equivalent dose (MED) in milligrams, a term used by CMS. Morphine equivalent dosing determines a patient's cumulative intake of all drugs in the opioid class over 24 hours in an effort to help reduce the likelihood of overdose.

Evidence/Resources

Dowell D, Haegerich TM, Chou R. [CDC Guideline for Prescribing Opioids for Chronic Pain](#). *MMWR Recomm Rep* 2016;65(No. RR-1):1–49

Additional References

Related Care Model Topics

- [Approach to Substance Use Disorders](#)
- [Depression in Adults](#)

Clinical Practice Guidelines

- Gutpa, A and R Rosenquist. [Use of opioids in the management of chronic non-cancer pain](#). *UpToDate*. 2018 Feb 07; Web.
- [New Mexico Clinical Guidelines on Prescribing Opioids for Treatment of Pain](#) (2011)
- [New Mexico Pain Management Advisory Council Recommendations](#) (2016)
- [Opioid Oral Morphine Milligram Equivalent \(MME\) Conversion Factors](#) (CMS 2018)
- [Opioid Overdose Clinical Tools](#) (CDC)

Training [PHS login required]

- [Grand Rounds: Complex Pain and Opioid Management](#)

- [Managing Controlled Substances – Epic Tip Sheet](#)
- [Pain and Addictions ECHO Clinic](#)
- [Pain Management and Opioid Therapy](#) (CME program)

Other Resources

- [Controlled Medication Treatment Agreement \(PHS Primary Care\)](#) [PHS login required]
- [New Mexico Prescription Monitoring Program \(PMP\)](#) (tip sheet)
- [Opioid Overdoses Treated in EDs – Fact Sheet](#) (CDC)
- [Patient Fact Sheet: Prescription Opioids](#) (CDC)
- [Patient Information Guide: Long-term Opioid Therapy for Chronic Pain](#) (VA)
- [Prescribe to Prevent \(Naloxone Education\)](#)
- [Prescription Opioid Safety](#) (New Mexico Dept. of Health)
- Swak, JA and L Timothy. [A Review of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain](#) [PHS login required]
- [16.10.14 NMAC](#)