UMassMemorial

OPIOID PAIN MEDICATION AGREEMENT

To help in getting my long standing pain in better control, and to help me reach the goals I have set (see pain goals), opioid pain medication is being prescribed for me. In order to make this medication safe and follow national and state laws, I __________________________ understand that:

(patient’s name)

- This medication may not take away all my pain.
- I should follow the directions given to me by my health care provider. I will not take more than what I am told to take.
- There are side effects of this medication described to me by my health care provider. All my questions about this medication have been answered.
- I will call my health care provider’s office if I am having side effects after starting this medication.
- This medication may make me sleepy. Driving or operating machinery while taking this medication can be dangerous.
- Taking alcohol or street drugs along with this medication is dangerous.
- My body may get used to the medication and if I stop it too quickly I could get sick.
- Some people have become addicted to these medications. If I think this is happening to me I will speak to my health care provider.

Patient’s Signature __________________________ Date ____________

I __________________________ agree:

(patient’s name)

- To obtain pain medication only from the health care provider signed below, or his/her medical team, and to notify my provider immediately if I obtain any pain medication from an emergency room.
- Only to get pain medication during regular office hours and not to call after office hours for pain medication.
- To fill my medications only at one pharmacy which is ____________________________
- To give urine samples and to bring in my pills to be counted whenever asked of me.
- Not to use illegal drugs along with this medication.
- Not to sell or give away my medication.
- To keep my medication safe. If it is lost or stolen I understand it may not be replaced.
- To allow my health care provider to exchange information with people who might need to know about my medication use if he/she thinks it is necessary for my health and safety.
- To keep all of my health care appointments recommended to me to treat my pain.
- That my medication can be stopped at any time, after a discussion with my health care provider.

Patient’s Signature __________________________ Date ____________

I __________________________ agree:

(health care provider’s name)

- To explain your pain condition and how opioids are expected to help.
- To explain the risks, side effects and alternatives to opioid treatment.
- To monitor your pain level at each visit to help assure good pain control and help meet your goals (see goal sheet).
- To continue to change the plan for pain control as needed to get good control of pain.
- To include a pain specialist and/or other health care specialists (such as Behavioral Health, Physical Therapy, Massage Therapy, Acupuncture and Osteopathic Manipulation) in your care, as needed to reach your goals.
- To keep you safe, to the best of my abilities, while you are taking opioid medications. I will provide help should you become addicted.

Health Care Provider’s Signature __________________________ Date ____________
Notes about treatment agreements

• Treatment Agreements are documents created by different practices to help provide education and information articulating rationale and risks of treatment
• Helps to counsel patient on the risks and benefits of opioid analgesics, and obtain verbal informed consent for their use
• They are NOT “pain contracts”
  • Using such language can impede patient-provider communication
• Efficacy not well established
  • No standard or validated form
  • No evidence they are detrimental
• But they are helpful
  • They should help a provider and patient have a conversation regarding the planned therapeutic regimen.
  • Takes “pressure” off provider to make individual decisions (Our clinic policy is…)

Issues to discuss in opioid agreement

• Discuss risks of opioid medications to help determine if benefits outweigh risks and to inform patients
  • Side effects – physical dependence – sedation
  • Drug interactions
  • Risk of misuse – abuse, addiction, death
  • Legal responsibilities – disposing, sharing
• Assign responsibility to look for early signs of harm
• Discuss monitoring, pill counts, drug tests, etc. as ways that help to protect patient from undue harm
  • Compare to statins and LFT monitoring analogy
  • Articulate monitoring (tox screen, pills counts) & action plans for aberrant medication taking behavior
• Use a consistent approach, but set level of monitoring to match risk

Adapted from Alford May 2010
Naloxone and opiate overdose

• Death generally occurs within 1-3 hours of overdose (Kin, 2009)
• Bystander Naloxone use is associated with increased odds of recovery (Giglio, 2015)
• Discuss Naloxone with all patients who have an opiate use disorder
• Explain signs and symptoms of overdose (handouts and videos may help)

Naloxone Co-Prescribing

• Should be considered with all chronic opiate prescriptions
  • Death generally occurs within 1-3 hours of overdose (Kim, 2009)
• Bystander naloxone use is associated with increased odds of recovery (Giglio, 2015)
• Explain signs and symptoms of overdose
  • Classic triad: pinpoint pupils/very small pupils, unconsciousness/not responsive/won’t wake up, respiratory depression/barely breathing/slow
• Share [handouts](#) and review naloxone use
• Share website with [videos](#) regarding OD recognition and naloxone use by patients and bystanders
Naloxone for Overdose Prevention

"IMPORTANT:

Administering Naloxone to someone who has NOT used opiates does NO harm"

How to Avoid Overdose
- Only take medicine prescribed to you
- Don't take more than instructed
- Call a doctor if your pain gets worse
- Never mix pain meds with alcohol
- Avoid sleeping pills when taking pain meds
- Dispose of unused medications
- Store your medicine in a secure place
- Learn how to use naloxone
- Teach your family + friends how to respond to an overdose

Are they breathing? Call 911 for help

Signs of an overdose:
- Slow or shallow breathing
- Gasping for air when sleeping or weird snoring
- Pale or bluish skin
- Slow heartbeat, low blood pressure
- Won't wake up or respond (rub knuckles on sternum)

All you have to say:
"Someone is unresponsive and not breathing."
Give clear address and location.

Rescue breathing
Oxygen saves lives. Breathe for them.
One hand on chin, tilt head back, pinch nose closed.
Make a seal over mouth & breathe in 1 breath every 5 seconds.
Chest should rise, not stomach.

Prepare Naloxone
Are they any better? Can you get naloxone and prepare it quickly enough that they won't go for too long without your breathing assistance?

PrescribeToPrevent.org

Evaluate + support
- Continue rescue breathing
- Give another 2 sprays of naloxone in 3 minutes if no or minimal breathing or responsiveness
- Naloxone wears off in 30-90 minutes
- Comfort them; withdrawal can be unpleasant
- Get them medical care and help them not use more opiate right away
- Encourage survivors to seek treatment if they feel they have a problem
## Naloxone Product Comparison

<table>
<thead>
<tr>
<th>Sig. (for suspected opioid overdose)</th>
<th>Injectable (and intranasal-IN) generic</th>
<th>Intranasal branded</th>
<th>Injectable generic&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Auto-injector branded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spray 1 ml (1/2 of syringe) into each nostril. Repeat after 2-3 minutes if no or minimal response.</td>
<td>Spray 0.1 mL into one nostril. Repeat with second device into other nostril after 2-3 minutes if no or minimal response.</td>
<td>Inject 1 mL in shoulder or thigh. Repeat after 2-3 minutes if no or minimal response.</td>
<td>Inject into outer thigh as directed by English voice-prompt system. Place black side firmly on outer thigh and depress and hold for 5 seconds. Repeat with second device in 2-3 minutes if no or minimal response.</td>
<td></td>
</tr>
</tbody>
</table>

### Ordering information

<table>
<thead>
<tr>
<th>How supplied</th>
<th>Box of 10 Luer-Jet™ prefilled glass syringes</th>
<th>Two-pack of single use intranasal devices</th>
<th>Box of 10 or package of 25 single-dose flitop vials (1 ml)</th>
<th>Case of 25 multi-dose flitop vials (10 ml)</th>
<th>Two pack of single use auto-injectors + 1 trainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturer</td>
<td>IMS/ Amphastar</td>
<td>Teleflex (off-label IN adapter)</td>
<td>Adapt Pharma</td>
<td>Pfizer, Mylan and West-Ward Pharmaceuticals</td>
<td>Pfizer</td>
</tr>
<tr>
<td>Customer service</td>
<td>800-423-4136 866-246-6990</td>
<td>844-462-7226</td>
<td>877-946-7747 (P) 724-514-1800 (M) 800-631-2174 (W)</td>
<td>877-946-7747 (P)</td>
<td>855-773-8946</td>
</tr>
<tr>
<td>NDC</td>
<td>76329-3369-01 DME- no NDC 69547-353-02 69547-212-04</td>
<td>00409-1215-01 (P) 67457-0292-02 (M) 0641-6132-25 (W)</td>
<td>00409-1219-01</td>
<td>60842-030-01 60842-051-01</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> Pfizer acquired Hospira in 2015. Pfizer has an additional naloxone product, which is not recommended for layperson and take-home naloxone use because it is complicated to assemble. (Naloxone Hydrochloride Injection, USP, 0.4 mg/mL Carpuject™ Luer Lock Glass Syringe (no needle) NDC# 0409-1782-69)

<sup>2</sup>This product concentration is not yet currently available. As a result, some of the content is left blank.

<sup>3</sup> EVZIO 2 mg is now available. As of February 2017, EVZIO 0.4 mg will no longer be manufactured, but is still currently available and effective.

<sup>4</sup>There is considerable price variance for each product- local pharmacists are able to provide specific local pricing.

Image development supported by 1R01DA038082-01 Friedmann/Rich
<table>
<thead>
<tr>
<th>NALOXONE PRICING IN THE COMMUNITY (As of January 2019)</th>
<th>Naloxone injection (0.4mg/mL)</th>
<th>Naloxone prefilled syringe (2 mg/2 mL)</th>
<th>Narcan® nasal spray (4 mg/0.1 mL)</th>
<th>Evzio® auto-injector (2 mg/0.4 mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Route of medication</td>
<td>Intramuscular only</td>
<td>Intranasal with atomizer</td>
<td>Intranasal</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>Cash Price based on goodrx.com¹</td>
<td>$12.80 to $21.13*</td>
<td>$20.99 to $36.85</td>
<td>$129.99 to $139.13</td>
<td>&gt;$3,720</td>
</tr>
<tr>
<td>CVS Pharmacy²</td>
<td>$18.99</td>
<td>$38.99</td>
<td>$95†</td>
<td>$2,225.99</td>
</tr>
<tr>
<td>Walgreens⁴</td>
<td>NA</td>
<td>$39.99</td>
<td>$135</td>
<td>NA</td>
</tr>
<tr>
<td>MassHealth</td>
<td>$3.65†</td>
<td>$3.65†</td>
<td>$3.65†</td>
<td>NA</td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>Commercial 3-Tier or 4-Tier Formulary Tier 1 or Tier 2 Tier 1 or Tier 2 Tier 3 or Tier 4 Tier 3 or Tier 4; PA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hybrid Formulary</td>
<td>Tier 1 $1</td>
<td>Tier 1 $1</td>
<td>Tier 4 50% coinsurance‡</td>
<td>Tier 3; PA $30</td>
</tr>
<tr>
<td>NaviCare (Medicare Part D)</td>
<td>Generic available through mail-order</td>
<td>Generic available through mail-order</td>
<td>Generic</td>
<td>NA</td>
</tr>
<tr>
<td>AllWays Health Partners §</td>
<td>3 Tier, 4 Tier, 5 Tier, 6 Tier Formulary Tier 1 or Tier 2 $0 Tier 2 or Tier 3 NA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tufts</td>
<td>Health RiTogether</td>
<td>Tier 1 NA</td>
<td>Tier 2; QL: 2 kits/30 days, 1 kit/Rx</td>
<td>Tier 2; QL: 4 kits/30 days, 2 units/Rx; PA</td>
</tr>
<tr>
<td>Health Direct</td>
<td>$0</td>
<td>NA</td>
<td>$0</td>
<td>Tier 3; QL: 4 kits/30 days, 2 units/Rx; PA</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of MA Standard</td>
<td>Standard 3-Tier Pharmacy Program Formulary Tier 1 Tier 3 Tier 3 Tier 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harvard Pilgrim Health Care</td>
<td>3-Tier Prescription Drug Plan $0; QL: 2 ml/15 days $0; QL: 2 ml/15 days $0; QL: 2 bottles/15 days Not covered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹=intramuscular, IV=intravenous, NA=not available, PA=prior authorization, QL=quantity limit, RX=prescription
*Price per mL
†MassHealth copayment
‡$400 maximum
§Formerly Neighborhood Health Plan
1. https://www.goodrx.com/
2. CVS Source: 1163 Providence Road, Whitinsville, MA
4. Walgreens Source: 99 Stafford Street, Worcester, MA
Naloxone Standing Order:
- Naloxone is available in Massachusetts without a prescription through a statewide standing order.

<table>
<thead>
<tr>
<th>Intranasal administration</th>
<th>Intramuscular injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naloxone 4 mg/0.1 mL nasal spray*</td>
<td>Naloxone 0.4 mg/mL in 1 mL single dose vials*</td>
</tr>
<tr>
<td>Directions for use: Administer a single spray of naloxone in one nostril. Repeat after 3 minutes if no or minimal response.</td>
<td>Directions for use: Inject 1 mL IM in shoulder or thigh. Repeat after 3 minutes if no or minimal response.</td>
</tr>
<tr>
<td>Naloxone 2 mg/2 mL single-dose Leur jet prefilled syringe†</td>
<td>Naloxone 2 mg/0.4 mL auto-injector*</td>
</tr>
<tr>
<td>Directions for use: Spray 1 mL in each nostril. Repeat after 3 minutes if no or minimal response.</td>
<td>Directions for use: Follow audio instructions from device. Place on thigh and inject 0.4 mL. Repeat after 3 minutes if no or minimal response.</td>
</tr>
</tbody>
</table>

*Dispense two doses
† Atomizer dispensed separately

Other resources related to naloxone procurement:
- Massachusetts Department of Public Health (DPH) Overdose Education and Naloxone Distribution (OEND) [https://www.mass.gov/service-details/information-for-community-members-about-how-to-get-naloxone](https://www.mass.gov/service-details/information-for-community-members-about-how-to-get-naloxone)
- AIDS Project Worcester provides free Narcan and Narcan training on a scheduled or walk-in basis through the Joe McKee Care Center. [https://www.aidsprojectworcester.org/narcan/](https://www.aidsprojectworcester.org/narcan/)
  - US citizens without insurance (commercial, state, or federal) and an annual household income <$100,000
Recognition of Opioid Overdose

- Classic triad:
  - Coma (depressed mental status)
  - Pinpoint pupils
  - Respiratory depression (<12 breaths/min in adults)
  - All three may not be present
  - Patients in recovery can be prescribed opiates when benefit outweights risk (such as major surgery, trauma), but there must be careful planning, open discussion, safe dispensing and close monitoring.
  - Increasingly opioid deaths involve fentanyl, either alone or in combination with heroin

### PHYSICIAN’S ORDERS
#### ADULT INTRAVENOUS
#### PATIENT-CONTROLLED ANALGESIA (PCA)

**Page 1 of 4**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inches</td>
<td>Cm.</td>
</tr>
<tr>
<td>Lbs.</td>
<td>Kg.</td>
</tr>
</tbody>
</table>

**ALLERGIES:**
- YES (LIST BELOW) or
- LISTED PREVIOUSLY
- NONE KNOWN

**BIRTHDATE/AGE:**

**SEX:**

**MEDICAL RECORD NUMBER:**

**EID/ACCOUNT NUMBER:**

**PROVIDER TO SIGN AND PLACE PAGER NUMBER LEGIBLY UNDER EACH ORDER SET**

**INDICATE CHOICE OF ORDER OPTIONS BY USING X IN CHECK BOXES**

**Attend/Change Attending To:**

**Resident:**

**Overnight coverage:**

**Intern/NP/PA (First Call):**

**House Staff Coverage:**
- Yes
- No (uncovered)

### ALL OTHER ORDERS

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Medication Orders Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Decontinue all previous opioids and benzodiazepines; additional opioids and benzodiazepines must be reordered with initiation of PCA</strong></td>
</tr>
</tbody>
</table>

1. Choose drug, dosing category, PCA dose

   **(CHOSE ONLY ONE DOSE CATEGORY):**

<table>
<thead>
<tr>
<th>Standard Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine: 1 mg/mL</td>
</tr>
<tr>
<td>PCA dose: _mg (usual dose 1mg, range 0.5 - 5mg)</td>
</tr>
<tr>
<td>HYDROMORPH: 0.2 mg/mL</td>
</tr>
<tr>
<td>PCA dose: _mg (usual dose 0.2 mg, range 0.1 - 1mg)</td>
</tr>
<tr>
<td>Fentanyl 20 mcg/mL</td>
</tr>
<tr>
<td>PCA dose: _mcg (usual dose 10 mcg, range 10 - 50 mcg)</td>
</tr>
</tbody>
</table>

   **Lockout Interval**
   - (usual 6 min; range 6-30 min)

   **High Dose (only for opioid-tolerant patients):**

   | Morphine: 5 mg/mL |
   | PCA dose: _mg (range 0.5 - 10 mg) |
   | HYDROMORPH: 1 mg/mL |
   | PCA dose: _mg (range 0.1 - 2 mg) |
   | Fentanyl 20 mcg/mL |
   | PCA dose: _mcg (range 10 - 100 mcg) |

   **Lockout Interval**
   - (usual 10 min; range 6-30 min)

   **Intractable Pain Use (requires palliative care or pain anesthesiology approval if not in ICU; only for opioid-tolerant patients):**

   | Morphine: 5 mg/mL |
   | PCA dose: _mg (no range) |
   | HYDROMORPH: 1 mg/mL |
   | PCA dose: _mg (no range) |
   | Fentanyl 20 mcg/mL |
   | PCA dose: _mcg (no range) |

   **Lockout Interval**
   - (usual 10 min; range 6-30 min)

2. One hr limit:

   **(includes max PCA doses**

   **Continuous Infusion in Alaris pump** (doses above the following require ordering the intractable pain dosing library. Please order as a separate infusion):

   **Pump Rate Limits**

   | Morphine: 1 mg/hr | 5 mg/hr |
   | HYDROMORPH: 0.2 mg/hr | 2 mg/hr |
   | Fentanyl 10 mcg/hr | 50 mcg/hr |

**Signature of MD/DO/NP/PA:**

**Printed Name:**

**Signature of RN:**

**Printed Name:**

**Date:**

**Time:**

**Prohibited Abbreviations:** U, qd, qod, qd, IU, .1 (write 0.1), 1.0 (write 1), MS, MSO4, MgSO4

810672 Rev 03/22/15
**CLINICAL GUIDE FOR CHANGING OPIOID ANALGESICS**

<table>
<thead>
<tr>
<th>Oral / Rectal (mg)</th>
<th>Analgesic</th>
<th>Parenteral (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>Codeine</td>
<td>100</td>
</tr>
<tr>
<td>300</td>
<td>Tramadol</td>
<td>-</td>
</tr>
<tr>
<td>30</td>
<td>Hydrocodone</td>
<td>-</td>
</tr>
<tr>
<td>30</td>
<td>Morphine</td>
<td>10</td>
</tr>
<tr>
<td>20</td>
<td>Oxycodone</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>Hydromorphone</td>
<td>1.5</td>
</tr>
<tr>
<td>(-)</td>
<td>Fentanyl</td>
<td>0.1 (100mcg)</td>
</tr>
<tr>
<td></td>
<td>Oxymorphone</td>
<td></td>
</tr>
</tbody>
</table>

**CALCULATING FORMULA**

To convert from one opioid or route of administration to another opioid or route of administration:

\[
\text{current opioid dose (mg), route} \times \left( \frac{\text{desired opioid}}{\text{current opioid}} \right) = \text{desired opioid dose (mg), route}
\]

**ADJUSTING FOR INCOMPLETE CROSS TOLERANCE**

Based on level of pain control at the time of conversion:

<table>
<thead>
<tr>
<th>Pain Control</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor pain control</td>
<td>100%</td>
</tr>
<tr>
<td>Moderate pain control</td>
<td>75%</td>
</tr>
<tr>
<td>Excellent pain control</td>
<td>50%</td>
</tr>
</tbody>
</table>

**FENTANYL CONVERSION**

*(not to be used for acute pain management)*

<table>
<thead>
<tr>
<th>Oral Morphine</th>
<th>50-100mg / 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl 25 mcg / hour patch</td>
<td></td>
</tr>
</tbody>
</table>

**ORAL/TRANSDERMAL AVAILABILITY OF COMMONLY PRESCRIBED OPIOIDS**

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Dosage Formulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol</td>
<td>50mg tablets</td>
</tr>
<tr>
<td>Morphine</td>
<td>Immediate-release: 30mg tablets</td>
</tr>
<tr>
<td></td>
<td>Controlled-release: 15mg, 30mg, 60mg, 100mg tablets</td>
</tr>
<tr>
<td></td>
<td>Oral solution: 20mg / 10mL, 20mg/mL</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Immediate-release: 5mg tablets</td>
</tr>
<tr>
<td></td>
<td>Controlled-release: 10mg, 20mg, 40mg tablets</td>
</tr>
<tr>
<td></td>
<td>Oral solution: 5mg / 5mL, 20mg/mL</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2mg, 4mg tablets</td>
</tr>
<tr>
<td></td>
<td>3mg suppositories</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Transdermal patches: 12mcg, 25mcg, 50mcg, 75mcg, 100mcg</td>
</tr>
</tbody>
</table>

*For specific questions regarding hospital formulary, please contact the main pharmacy.*

*(Memorial Campus X46356, University Campus X62775)*
### Physician's Orders

**Adult Intravenous Patient-Controlled Analgesia (PCA)**

**Height**
- Inches: [ ]
- Cm: [ ]

**Weight**
- Lb: [ ]
- Kg: [ ]

**Allergies**
- Yes (List Below) or Listed Previously
- None Known

---

**Attending/Change Attending To:**
- First: [ ]
- Last: [ ]

**Resident:**
- Pager: [ ]

**Intern/NP/PA (First Call):**
- Pager: [ ]

**Overnight Coverage:**
- Pager: [ ]

**House Staff Coverage:**
- Yes [ ]
- No [ ] (uncovered)

---

**ALL OTHER ORDERS**

**1. Prevention of Constipation:**
- Senna 2 tabs PO BID (hold for >3 loose stools/day) [ ]
- Docusate sodium (Colace) 100mg PO BID (hold for >3 loose stools/day) [ ]
- Other: [ ]

**2. Treatment of Constipation**
- Polystyrene glycol (MiraLax): 17gm PO daily if >24hrs without BM [ ]
- Milk of magnesia: 30mL PO q6hrs PRN if >24hrs without BM [ ]
- Bisacodyl (Dulcolax): 10mg PR q6hrs PRN if unable to take PO and/or >24 hrs without BM despite oral laxatives [ ]
- High tsp water enema: PR daily PRN > 48 hrs without BM and bisacodyl PR unsuccessful [ ]
- Other: [ ]

**3. Treatments PRN Nausea/Vomiting (N/V) (choose one):**
- Metoclopramide (Reglan): 10mg IV q6hrs PRN nausea/vomiting (first choice for patients with impaired GI motility) [ ]
- Ondansetron (Zofran): 4mg IV q6hrs PRN nausea/vomiting (first choice for patients post-anesthesia or receiving cancer-directed therapy) [ ]
- Other: [ ]

---

**MEDICATION ORDERS ONLY**

**4. Treatments PRN Pruritus:**
- Diphenhydramine (Benadryl): 125-250mg IV q4hrs PRN pruritus [ ]
- Other: [ ]

**5. Treatments PRN Respiratory Depression:**
- If patient is hemodynamically stable with signs of respiratory depression (e.g., RR < 10 and [PO2 ≥ 90 or RASS < 0])
  - Administer O2 at 4L/min by NC [ ]
  - Stop opioid infusion [ ]
  - Call MD/LIP and [ ]
    - If patient is hemodynamically unstable with RR < 10 and (PO2 ≥ 90 or RASS < 0)
      - Administer Narcan: 0.2mg IV every 3 minutes up to 0.4mg PRN and every 2 hours PRN; higher doses may be required if high suspicion for opioid-induced respiratory depression
- Call CODE BLUE if patient full code or call MD/LIP if DNR/DNI [ ]
  - Administer Narcan: 0.2mg IV every 3 minutes up to 0.4mg PRN and every 2 hours PRN; higher doses may be required if high suspicion for opioid-induced respiratory depression [ ]

---

**Signature of MD/DO/NP/PA:** [ ]
**Printed Name:** [ ]
**Pager:** [ ]

**Signature of RN:** [ ]
**Printed Name:** [ ]
**Date:** [ ]
**Time:** [ ]

---

Prohibited Abbreviations: U, qd, qod, IU, .1 (write 0.1), 1.0 (write 1), MS, MSO4, MgSO4

810672 Rev 03/22/15
Suggestions Regarding Treatment of Side Effects:

Constipation:
The daily regimen should be increased if frequent rescue medication for constipation is necessary.
1. Opioid reduce peristalsis. All patients on opioids need a daily stimulant laxative to prevent constipation, as well as rescue medication if constipation persists.
2. Consider the following protocol:
   i. Start with senna (max of 8 tabs/day) and docusate
   ii. Order oral and rectal laxatives PRN and use if no bowel movement in 1-2 days.
   iii. Titrate daily maintenance regimen as needed.
3. Note Some patients are not appropriate to receive rectal laxatives or enemas (e.g. patients with neutropenia).

Nausea/Vomiting: tolerance will usually develop to opioid induced nausea/vomiting
1. Constipation may contribute or be the source of nausea so be sure to treat the constipation.
2. Consider pathophysiology of patients’ nausea to guide treatment.
3. For opioid-induced nausea, dopamnergic agents can work best.
   i. Metoclopramide - can also help with poor GI motility (watch for drug induced movement disorders)
   ii. Haloperidol - non-sedating, 0.5mg IV every 6 hours PRN (watch for drug induced movement disorders)
   iii. Prochlorperazine (Compazine) 25mg PR every 12 hours PRN nausea/vomiting
   iv. Cndasetron - can be effective, especially in post-op setting; can cause constipation and headache

Pruritus:
1. Consider opioid rotation
2. Diphenhydramine can decrease the opioid induced histamine release that triggers itching.
UMASS MEMORIAL MEDICAL CENTER
PHYSICIAN'S ORDERS
CHRONIC PANCREATITIS
Page 1 of 4

ALL OTHER ORDERS

| Diagnosis: Chronic Pancreatitis Day 1 |
| Status: INPATIENT must meet BOTH of the following: |
| □ Worsening abdominal pain |
| □ Unresponsive to >3 doses analgesia (includes PO) within last 24 hrs |
| NURSING: |
| □ Pulse Ox and vital signs every shift |
| □ Apply O2 NC to keep: |
| Please circle: O2sat > 92% or O2sat 88-92% |
| □ Call provider if patient temp >30.0°C, BP <90, HR <50, Hb <100 |
| □ Call provider if patient leaves unit except for testing |
| Patient to remain on unit while on PCA for safety |
| Activity: |
| □ Ambulate with assistance, advance activity per Nursing assessment |
| □ Out of bed |
| □ Ambulate with assistance in half 3x day |
| □ Other: |
| Diet: □ NPO |

IV: Normal saline IV @ mL/hr for

Labs: □ CBC, BMP, Mag & Phos (if not done in ED) |
| □ Amylase/Lipase/Albumin/Prealbumin (if not done in ED) |
| □ Hepatic Panel |
| □ ALc blood alcohol level (if not done in ED) |
| □ UTOX urine tox screen (if not done in ED) |
| □ COHB Carboxyhemoglobin to assess for recent smoking (if not done in ED) |

Other: For Tracking Purposes

□ Patient of the UMMMC Pancreatitis Clinic
Has patient had confirmation of pancreatitis diagnosis by EUS, CT scan or secretion stimulation test? □ Yes □ No

Consults: □ Tobacco Cessation (for smokers unwilling to stop) |
| □ Gastroenterology (recommended for patients without confirmed diagnosis) |
| □ Social Work |
| □ Health Psychology consult, Ext 62148 |

Advanced Directive: |
| □ Full Code |
| □ DNR (complete Orders for Limitation of Treatment Directives, form ID 810194) |

Signature of MD/DO/NP/PA: _________ Printed Name: _________ Pager: _________

Signature of RN: _________ Printed Name: _________ Date: _________ Time: _________

Prohibited Abbreviations: U, qd, qod, IU, .1 (write 0.1), 1.0 (write 1), MS, MSO4, MgSO4
NS ORDER 0232 Rev 07/22/13
**UMASS MEMORIAL MEDICAL CENTER**
**PHYSICIAN'S ORDERS**
**CHRONIC PANCREATITIS**
Page 2 of 4

**Height**  
- Inches: [ ]  
- Cm: [ ]  
**Weight**  
- Lbs: [ ]  
- Kg: [ ]  
**ALLERGIES:**  
- YES (LIST BELOW) OR [ ] LISTED PREVIOUSLY  
- NONE KNOWN

**NAME:**  
**ADDRESS:**  
**BIRTHDATE/AGE:**  
**SEX:**  
**MEDICAL RECORD NUMBER:**

**PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD**

**PROVIDER TO SIGN AND PLACE PAGER NUMBER LEGIBLY UNDER EACH ORDER SET**

**INDICATE CHOICE OF ORDER OPTIONS BY USING X IN CHECK BOXES**

**Attending/Change Attending To:**  
- (First)  
- (Last)  
**Pager:**  

**Resident:**  
**Pager:**  

**Intern/NP/PA (First Call):**  
**Pager:**  

**Overnight coverage:**  
**Pager:**  

**House Staff Coverage:**  
- Yes  
- No (uncovered)

---

**ALL OTHER ORDERS**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pancreatitis Day 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- No routine follow-up CBC, BMP, Mg, Phos, amylase, lipase recommended unless clinically indicated to follow a comorbid condition.

**Activity:**
- *All patients should be transitioned to oral pain management unless one of the below conditions exist (please check):*
  - Out of bed to chair for all meals and toileting  
  - Unable to tolerate PO  
  - Uncontrolled pain

**Diet:**
- *Note: recommend advancing diet if pain improving*
  - Clear liquids

**Consults:**
- Gastroenterology (consider if failing to improve)  
- PT (recommended if patient is not ambulating at baseline)  
- Other:

**Pain Control Regimen:**
- D/C PCA and resume home pain regimen (MD must order individual medications)

**REMINDER:** Please plan for discharge now by obtaining PCP and Pancreatitis Clinic follow-up appointments.

---

**Signature of MD/DO/NP/PA:**  
**Printed Name:**  
**Pager:**  

**Signature of RN:**  
**Printed Name:**  
**Date:**  
**Time:**  

Prohibited Abbreviations:  
- U, qd, qod, IU, .1 (write 0.1), 1.0 (write 1), MS, MSO4, MgSO4

NS ORDER 0232 Rev 07/22/13
UMASS MEMORIAL MEDICAL CENTER
PHYSICIAN'S ORDERS
CHRONIC PANCREATITIS
Page 3 of 4

<table>
<thead>
<tr>
<th>Allergies:</th>
<th>Yes (List Below) OR Listed Previously</th>
</tr>
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<tbody>
<tr>
<td>Height</td>
<td>Inches: ____________ Lbs: ____________</td>
</tr>
<tr>
<td>Weight</td>
<td>Kg: ____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider to Sign and Place Pager Number Legibly Under Each Order Set</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Attending/Change Attending To: ____________________________ Pager: ____________</th>
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</thead>
<tbody>
<tr>
<td>Resident: ____________________________ Pager: ____________________________ Overnight coverage: ____________________________ Pager: ____________________________</td>
</tr>
<tr>
<td>Intern/NP/PA (First Call): ____________________________ Pager: ____________________________ House Staff Coverage: Yes No (uncovered)</td>
</tr>
</tbody>
</table>

### All Other Orders

<table>
<thead>
<tr>
<th>Diagnosis: Chronic Pancreatitis Day 3</th>
</tr>
</thead>
</table>

- Discharge today as all the following stability criteria are met:
  - Tolerating diet (able to tolerate > 300 mL of fluids)
  - Pain controlled and converted to PO
  - Ambulating

- Continue Inpatient Admission as above criteria not met

**Activity:**

- Encourage ambulation
- Out of bed to chair for all meals and toileting
- Other: 

**Diet:**

- Low fat
- Clear liquids
- Other: 

**Labs:**

- COHB Carboxyhemoglobin (consider for smokers who are failing to improve)

**Consults:**

- Nutrition (recommended for patients < 30 mL oral intake of fluids)
- PT (recommended if patient is not ambulating at baseline)

### Medication Orders Only

- See Medication Reconciliation Order Form for preadmission medications.
- New or Changed Medications:
- *All patients should be transitioned to oral pain management unless one of the below conditions exist (please check):*
  - Unable to tolerate PO
  - Pain Control Regimen:
    - D/C PCA and resume home pain regimen (MD must order individual medications)
    - Note: If patient reports pain not controlled, contact Health Psychology.

**Signature of MD/DO/NP/PA: ____________________________ Printed Name: ____________________________ Pager: ____________**

**Signature of RN: ____________________________ Printed Name: ____________________________ Date: ____________ Time: ____________**

Prohibited Abbreviations: U, qd, qod, IU (.1 write 0.1), 1.0 (write 1), MS, MSO4, MgSO4

NS ORDER 0232 Rev 07/22/13
UMASS MEMORIAL MEDICAL CENTER
PHYSICIAN'S ORDERS
CHRONIC PanCREATITIS
Page 4 of 4

<table>
<thead>
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<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
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<td>Cm.</td>
</tr>
<tr>
<td>Lbs.</td>
<td>Kg.</td>
</tr>
</tbody>
</table>

ALLERGIES: [ ] YES (LIST BELOW) OR [ ] LISTED PREVIOUSLY
[ ] NONE KNOWN

M E D I C A L  R E C O R D  N U M B E R:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

PROVIDER TO SIGN AND PLACE PAGER NUMBER LEGIBLY UNDER EACH ORDER SET
INDICATE CHOICE OF ORDER OPTIONS BY USING X IN CHECK BOXES

Attending/Change Attending To: ____________________________ (First) ____________________________ (Last) Pager: __________

Resident: ____________________________ Pager: __________ Overnight coverage: __________ Pager: __________

Intern/NP/PA (First Call): ____________________________ Pager: __________

House Staff Coverage: [ ] Yes [ ] No (uncovered)

ALL OTHER ORDERS

<table>
<thead>
<tr>
<th>Diagnosis: Chronic Pancreatitis Day 4</th>
<th>DATE</th>
<th>TIME</th>
</tr>
</thead>
</table>

[ ] Discharge today as all the following stability criteria are met:
- Tolerating diet (able to tolerate > 300 mL of fluids)
- Pain controlled and converted to PO
- Ambulating

[ ] Continue Inpatient Admission as the following criteria not met:

Activity:

Note: encourage ambulation

[ ] Out of bed to chair for all meals and toileting
[ ] Other:

Diet:

[ ] Low fat
[ ] Clear liquids
[ ] Other:

Labs:

[ ] CO2H Carboxyhemoglobin (consider for smokers who are failing to improve)

Consults:

[ ] Nutrition (recommended for patients < 300 mL oral intake of fluids)
[ ] PT (recommended if patient is not ambulating at baseline)

Signature of MD/DO/NP/PA: ____________________________ Printed Name: ____________________________ Pager: __________
Urine Toxicology Screening

- No unified guidelines for urine toxicology screening but generally
  - Twice per year for low risk patients
  - At least monthly in higher risk patients or those with aberrant behavior
- Urine tox screens differ by labs, you must check those where you work; generally assess for
  - Opiates, benzodiazepines, barbiturates, cocaine, THC (principle active component of cannabis), amphetamine
  - See additional resources on the OSTI website

Urine Screen for Opioids

- Possible reasons for negative urine opiate screens
  - Immunoassays for opiates are based on finding morphine in the urine, which is the metabolite for morphine, codeine, and heroin.
  - These tests do not reliably detect synthetic and semisynthetic opioids, such as oxycodone, hydrocodone, methadone, buprenorphine, or fentanyl.
- If a provider needs to test for the presence of synthetic and semisynthetic opioids, he or she must order specific testing for these agents and communicate with the lab to make sure that the right type of testing is used for each patient.
Interpretation of Opioid Urine Drug Screens

Summary

Urine drug testing is highly reliable, but false positives can rarely occur for some drugs. As always, clinical judgment is necessary when interpreting test results. The length of time a drug can be detected in the urine varies due to several factors, including hydration, dosing, metabolism, body mass, urine pH, duration of use, and a drug’s particular pharmacokinetics.

(See table below for some “average” times for different drugs.)

<table>
<thead>
<tr>
<th>Length of Time Drugs of Abuse Can Be Detected in Urine Drug</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>7-12 h</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>48 h</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>48 h</td>
</tr>
<tr>
<td><strong>Barbiturate</strong></td>
<td></td>
</tr>
<tr>
<td>Short-acting (eg, pentobarbital)</td>
<td>24 h</td>
</tr>
<tr>
<td>Long-acting (eg, phenobarbital)</td>
<td>3 wk</td>
</tr>
<tr>
<td><strong>Benzodiazepine</strong></td>
<td></td>
</tr>
<tr>
<td>Short-acting (eg, lorazepam)</td>
<td>3 d</td>
</tr>
<tr>
<td>Long-acting (eg, diazepam)</td>
<td>30 d</td>
</tr>
<tr>
<td>Cocaine metabolites</td>
<td>2-4 d</td>
</tr>
<tr>
<td><strong>Marijuana</strong></td>
<td></td>
</tr>
<tr>
<td>Single use</td>
<td>3 d</td>
</tr>
<tr>
<td>Moderate use (4 times/wk)</td>
<td>5-7 d</td>
</tr>
<tr>
<td>Daily use</td>
<td>10-15 d</td>
</tr>
<tr>
<td>Long-term heavy smoker</td>
<td>30 d</td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>48 h</td>
</tr>
<tr>
<td>Heroin (detected as morphine)</td>
<td>48 h</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2-4 d</td>
</tr>
<tr>
<td>Methadone</td>
<td>3 d</td>
</tr>
<tr>
<td>Morphine</td>
<td>48-72 h</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>2-4 d</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>6-48 h</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>8 d</td>
</tr>
</tbody>
</table>

-- Mayo Clinic Proc. 2008; 83(1)66-76

Sometimes the specific drug ingested is not detected, but instead one of its metabolites is found.

References: Health Partners Institute
Fentanyl (Duragesic) is not easily detected in either urine or serum.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Half-life (hr)</th>
<th>Metabolites</th>
<th>Concentrations above the cutoff will screen positive for</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine</td>
<td>1.5 - 6.5</td>
<td>normorphine, hydromorphone (&lt;2.5%)</td>
<td>Opiates</td>
</tr>
<tr>
<td>codeine</td>
<td>1 - 4</td>
<td>morphine, hydrocodone (&lt;11%), norcodeine</td>
<td>Opiates</td>
</tr>
<tr>
<td>oxycodone</td>
<td>4 - 12</td>
<td>oxymorphone, noroxycodone</td>
<td>Opioid</td>
</tr>
<tr>
<td>oxymorphone</td>
<td>3 - 6</td>
<td>6-hydroxy-oxymorphone</td>
<td>Opioid</td>
</tr>
<tr>
<td>hydrocodone</td>
<td>3.5 - 9</td>
<td>hydromorphone, norhydrocodone, dihydrocodeine</td>
<td>Opiates</td>
</tr>
<tr>
<td>hydromorphone</td>
<td>3 - 9</td>
<td>hydromorphol</td>
<td>Opiates</td>
</tr>
</tbody>
</table>

For more information visit:
https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/DrugsofAbuseTests/default.htm

References: Health Partners Institute
Clinical Guide for Changing Opioid Analgesics

<table>
<thead>
<tr>
<th>Oral/Rectal (mg)</th>
<th>Analgesic</th>
<th>Parenteral (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>200 mg</td>
<td>Codeine</td>
<td>-</td>
</tr>
<tr>
<td>300mg</td>
<td>Tramadol*</td>
<td>-</td>
</tr>
<tr>
<td>30 mg</td>
<td>Hydrocodone</td>
<td>-</td>
</tr>
<tr>
<td>30 mg</td>
<td>Morphine</td>
<td>10 mg</td>
</tr>
<tr>
<td>20 mg</td>
<td>Oxycodone</td>
<td>-</td>
</tr>
<tr>
<td>6 mg</td>
<td>Hydromorphone</td>
<td>1.5 mg</td>
</tr>
<tr>
<td>-</td>
<td>Fentanyl</td>
<td>0.1 mg (100mcg)</td>
</tr>
</tbody>
</table>

Fentanyl Conversion

(Not to be used for acute pain management.)

Oral morphine 50 - 100 mg/24 hours ~
Fentanyl 25 mcg/hour patch

Oral/Transdermal Availability of Commonly Prescribed Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>15 mg, 30 mg tablets</td>
</tr>
<tr>
<td>Tramadol</td>
<td>50 mg tablets</td>
</tr>
<tr>
<td>Morphine</td>
<td>Immediate-release: 30 mg tablets</td>
</tr>
<tr>
<td></td>
<td>Controlled-release: 15 mg, 30 mg, 60 mg, 100 mg tablets</td>
</tr>
<tr>
<td></td>
<td>Oral solution: 20mg/10ml, concentrate: 20mg/ml</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Immediate-release: 5 mg tablets</td>
</tr>
<tr>
<td></td>
<td>Controlled-release: 10 mg, 20 mg, 40 mg tablets</td>
</tr>
<tr>
<td></td>
<td>Oral solution: 5 mg/5ml, concentrate: 20 mg/ml</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2 mg, 4 mg tablets</td>
</tr>
<tr>
<td></td>
<td>3 mg suppositories</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Transdermal patches: 25 mcg, 50 mcg, 75 mcg, 100 mcg</td>
</tr>
</tbody>
</table>

Combination Products:

<table>
<thead>
<tr>
<th>Combinations</th>
<th>Tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine/APAP (Tylenol #3)</td>
<td>30mg codeine/300 mg acetaminophen tablets</td>
</tr>
<tr>
<td></td>
<td>Oral solution: 36 mg codeine/360 mg acetaminophen/5 ml</td>
</tr>
<tr>
<td>Hydrocodone/APAP (Vicodin)</td>
<td>5 mg hydrocodone/500 mg acetaminophen tablet</td>
</tr>
<tr>
<td>Oxycodone/APAP (Percocet)</td>
<td>5 mg oxycodone/325 mg acetaminophen tablet</td>
</tr>
</tbody>
</table>

Calculation Formula

To convert from one opioid or route of administration to another opioid or route of administration:

current opioid dose (mg), route \times \left( \frac{\text{desired opioid dose (mg), route}}{\text{current opioid dose (mg), route}} \right) = \text{desired opioid dose (mg), route}

Adjusting for Incomplete Cross Tolerance

Based on level of pain control at the time of conversion

<table>
<thead>
<tr>
<th>Level of Pain Control</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor pain control</td>
<td>100%</td>
</tr>
<tr>
<td>Moderate pain control</td>
<td>75%</td>
</tr>
<tr>
<td>Excellent pain control</td>
<td>50%</td>
</tr>
</tbody>
</table>

UMassMemorial
Safety Monitoring Guidelines

- Discuss the risks and benefits of opioid treatment with your patients openly.
- Thoroughly assess for risk of substance misuse disorder initially and continue monitoring for aberrant behavior.
- For chronic opioids, establish prescription medication treatment agreement and review it periodically with patient (at least annually).
- Perform urine toxicology screening (see below).
- Perform pill counts.
- Utilize the prescription drug monitoring program website.
- Follow universal precautions! (see below).

*Note: Chronic pain is defined as lasting >12 weeks (ICD 10)*
Universal Precautions for safe prescribing of opiate medications

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Make a diagnosis with appropriate differential and a plan for further evaluation and investigation of underlying conditions to try to address the medical condition that is responsible for the pain.</td>
</tr>
<tr>
<td>2.</td>
<td>Psychologic assessment, including risk of addictive disorders.</td>
</tr>
<tr>
<td>3.</td>
<td>Informed consent.</td>
</tr>
<tr>
<td>4.</td>
<td>Treatment agreement.</td>
</tr>
<tr>
<td>5.</td>
<td>Pre-/post-treatment assessment of pain level and function.</td>
</tr>
<tr>
<td>6.</td>
<td>Appropriate trial of opioid therapy +/- adjunctive medication.</td>
</tr>
<tr>
<td>7.</td>
<td>Reassessment of pain score and level of function.</td>
</tr>
<tr>
<td>8.</td>
<td>Regularly assess the “Four As” of pain medicine:&lt;br&gt;• Analgesia, Activity, Adverse reactions, and Aberrant behavior.</td>
</tr>
<tr>
<td>9.</td>
<td>Periodically review management of the underlying condition that is responsible for the pain, the pain diagnosis and comorbid conditions relating to the underlying condition, and the treatment of pain and comorbid disorders.</td>
</tr>
<tr>
<td>10.</td>
<td>Documentation of medical management and of pain management according to state guidelines and requirements for safe prescribing.</td>
</tr>
</tbody>
</table>

Red and Yellow Flag Behaviors for Substance Use Disorders

**Red**
- Deterioration in functioning at work or socially
- Illegal activities—selling medications, forging prescriptions, or buying medications from nonmedical sources
- Using medications in ways other than prescribed (e.g., injecting or snorting medication)
- Multiple reports of lost or stolen prescriptions
- Resistance to change in medications despite adverse effects
- Refusal to comply with random drug screens, call backs, or pill counts
- Concurrent abuse of alcohol or drugs
- Use of multiple physicians and pharmacies

**Yellow (could be normal but combined may be of concern)**
- Complaints about need for more medication
- Drug hoarding
- Nonadherence to recommendations for non-medication pain therapies
- Acquiring similar medications from other providers
- Occasional unsanctioned dose escalation
- Requesting specific pain medications
- Taken in the context of a patient’s presentation and history, this
  - could be a sign of “seeking” certain medications, or if patients ask
  - for specific medications it could be because this has worked in
  - the past. (consider a patient asking for a specific blood pressure
  - medicine that has worked well in the past, providers would likely
  - restart it immediately)
Key Concepts for OSTI

- Opioid use disorder is and should be treated as a chronic illness.
- The opiate epidemic has impacted communities of color for years. The current national focus suggests bias in the healthcare system, policy-makers and media.
- Safe-prescribing does **not** mean NO prescribing, even for patients in recovery.
- The prescription monitoring program (PMP or MassPAT) provides accurate, up-to-date prescribing information and must be accessed before prescribing.
- Co-prescribing naloxone should be considered for any patient on chronic opiates.
- Best practices include risk assessment (including for diversion), informed consent, monitoring, safe storage and disposal counseling.
- Medication assisted treatment/Medications for opioid use disorder with agents such as methadone, buprenorphine or naltrexone can act as a bridge or long-term therapy to assist patients in overcoming opioid use disorders.