Managing pain for patients in recovery

- Non-pharmacological pain control may be beneficial. Some patients in recovery from SUDs may prefer to avoid the use of any medication. Evidence shows that stress management, CBT, manual therapies, and acupuncture offer effective relief for certain types of acute pain (Hurwitz et al., 2008; Vernon, Humphreys, & Hagino, 2007).
- Switch from short- to long-acting medications as quickly as appropriate (to minimize reinforcing effects). They may also benefit from bolstered recovery support during postoperative periods (Covington, 2008).

Patients on agonist therapy for pain or addiction

- may be continued on their current opioid or on an equivalent dose of an alternative opioid;
- Acute pain will likely require supplementation with (often greater-than-usual doses of) additional opioids. In this situation, adjuvant NSAIDs may allow clinicians to provide pain relief with a reduction in opioid dosage (Mehta & Langford, 2006), and multimodal analgesia should be considered (Maheshwari, Boutary, Yun, Sirianni, & Dorr, 2006).

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

Height	Weight
Inches _____ Cm. _____	Lbs. _____ Kg. _____

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

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

ECD / ACCOUNT NUMBER:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

3

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	DATE	TIME	MEDICATION ORDERS ONLY
1. Assess pain and sedation level as per hospital policy, using			☒ Discontinue all previous opioids and benzodiazepines; additional
appropriate tools (e.g. POSS, RASS).			opioids and benzodiazepines must be re-ordered with initiation of PCA
2. Obtain vital signs, pain, and sedation levels prior to initiation			
or change in PCA. Then monitor vital signs, pain, and sedation			1. Choose drug, dosing category, PCA dose*
levels every 15 min x 4, every hour x 4, then every 4 hours.			(CHOOSE ONLY ONE DOSE CATEGORY):
3. ☐ Monitor continuous pulse oximetry for first 24 hrs. Page PCA			**Standard Dose :**
ordering team thereafter to continue monitoring as needed.			☐ Morphine 1 mg/mL
4. Call MD/LIP for:			PCA dose: ___ mg (usual dose 1mg, range 0.5 - 5mg)
• Respiratory rate < 10 or SpO2 < 93%			☐ HYDROmorphone 0.2 mg/mL
• Unsatisfactory analgesia > 1 hour from previous adjustment			PCA dose: ___ mg (usual dose 0.2mg, range 0.1 - 1.4mg)
• Increasing sedation (POSS score ≥ 3 or RASS < 0)			☐ FentaNYL 20 mcg/mL
• Unsatisfactorily treated nausea/vomiting or pruritus			PCA dose: ___ mcg (usual dose 10 mcg, range 10 - 50mcg)
5. If no other IV ordered, use NS at 30mL/hr to maintain IV			Lockout Interval: (usual 6 min; range 6-30 min)
access for PCA			**High Dose (only for opioid-tolerant patients):**
6. Educate the patient and family on the proper use of the PCA			☐ Morphine 5 mg/mL
pump			PCA dose: ____ mg (range 0.5 - 10 mg)
			☐ HYDROmorphone 1 mg/mL
***Note:** Morphine is the initial drug of choice if the patient has			PCA dose: ____ mg (range 0.1 - 2 mg)
normal renal function.			☐ FentaNYL 20 mcg/mL
			PCA dose: ____ mcg (range 10 - 100 mcg)
			Lockout Interval: (usual 10 min; range 6-30 min)
			Intractable Pain Dose (use requires palliative care or pain
			anesthesia approval if not in ICU; only for opioid-tolerant patients):
			☐ Morphine 5 mg/mL
			PCA dose: ____ mg (no range)
			☐ HYDROmorphone 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
***Note:** Hard ranges for ****continuous infusion** in Alaris pump			+ continuous doses total in 1 hour)
(doses above the following require ordering the intractable pain			3. PCA ****continuous infusion** (Only for opioid-tolerant patients.
dosing library. Please order as a separate infusion.):			Strongly recommend input from anesthesia or palliative care if not in ICU)
Pump Rate Limits **Standard Dose** **High Dose**			☐ _____
Morphine 1mg/hr 5mg/hr			☐ 23:00PM - 7:00AM, _____ / hour
HYDROmorphone 0.2mg/hr 2mg/hr			
FentaNYL 10mcg/hr 50mcg/hr			(For orders PRN respiratory depression, see page 3)

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

CLINICAL GUIDE FOR CHANGING OPIOID ANALGESICS

Oral / Rectal (mg)	**Analgesic**	**Parenteral** (mg)
200	Codeine	100
300	Tramadol	-
30	Hydrocodone	-
30	Morphine	10
20	Oxycodone	-
6	Hydromorphone	1.5
(-)	Fentanyl	0.1 (100mcg)
	Oxymorphone	

CALCULATING FORMULA

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

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

ADJUSTING FOR INCOMPLETE CROSS TOLERANCE

Based on level of pain control at the time of conversion	
Poor pain control	100%
Moderate pain control	75%
Excellent pain control	50%

FENTANYL CONVERSION

(not to be used for acute pain management)

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

ORAL/TRANSDERMAL AVAILABILITY OF COMMONLY PRESCRIBED OPIOIDS

Tramadol	50mg tablets
Morphine	Immediate-release: 30mg tablets Controlled-release: 15mg, 30mg, 60mg, 100mg tablets Oral solution: 20mg / 10mL, 20mg/mL
Oxycodone	Immediate-release: 5mg tablets Controlled-release: 10mg, 20mg, 40mg tablets Oral solution: 5mg / 5mL, 20mg/mL
Hydromorphone	2mg, 4mg tablets 3mg suppositories
Fentanyl	Transdermal patches: 12mcg, 25mcg, 50mcg, 75mcg, 100mcg

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	Weight
Inches _____ Cm. _____	Lbs. _____ Kg. _____

ALLERGIES: ☐ YES (LIST BELOW) OR ☐ LISTED PREVIOUSLY
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BIRTHDATE/AGE: SEX:

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Resident: _____ **Pager:** _____ **Overnight coverage:** _____ **Pager:** _____

Intern/NP/PA (First Call): _____ **Pager:** _____ **House Staff Coverage:** ☐ **Yes** ☐ **No (uncovered)**

ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
1. Prevention of Constipation:			**4. Treatments PRN Pruritus:**
☐ Senna 2 tabs PO BID (hold for >3 loose stools/day)			☐ Diphenhydramine (Benadryl) 12.5-25mg IV q4hrs PRN pruritus
recommended			☐ Other:
☐ Docusate sodium (Colace) 100mg PO BID (hold for >3			
loose stools/day) recommended			**5. Treatments PRN Respiratory Depression:**
☐ Other:			☒ If patient is hemodynamically stable with signs of
			respiratory depression (e.g. RR <10 and [POSS ≥ 3
2. Treatment of Constipation			or RASS < 0])
Choose one Oral Laxative:			(a) administer O2 at 4L/min by NC
☐ Polyethylene glycol (Miralax) 17gm PO daily if >24hrs without BM			(b) stop opioid infusion
☐ Milk of magnesia 30mL PO q6hrs PRN if >24hrs without BM			(c) call MD/LIP and
Choose Rectal PRN Laxative(s):			(d) use 1mL luer-lock syringe with Naloxone 0.4mg/1mL
☐ Bisacodyl (Dulcolax) 10mg PR q6hrs PRN if unable to			vial and administer Naloxone 0.04mg IV (0.1mL)
take PO and/or >24 hrs without BM despite oral laxatives			every 3 minutes up to 0.12mg IV PRN
☐ High tap water enema PR daily PRN > 48 hrs without BM			☒ If patient is hemodynamically unstable with RR <10 and
and bisacodyl PR unsuccessful			(POSS ≥ 3 or RASS < 0)
☐ Other:			(a) call CODE BLUE if patient full code or call MD/LIP
			if DNR/DNI
3. Treatments PRN Nausea/Vomiting (N/V) (choose one):			(b) administer Naloxone 0.2mg IV every 3 minutes up to
☐ Metoclopramide (Reglan) 10mg IV q6hrs PRN nasuea/			0.4mg PRN and every 2 hours PRN; higher doses
vomiting (first choice for patients with impaired GI motility)			may be required if high suspicion for opioid-induced
☐ Ondansetron (Zofran) 4mg IV q8hrs PRN nausea/vomiting			respiratory depression
(first choice for patients post-anesthesia or receiving			
cancer-directed therapy)			
☐ Other:			

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

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, dopamandergic agents can work best.
   i. Metoclopramide - can also help with poor GI motility (watch for drug induced movement disorders)
   ii. Haldoperidol - 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. Ondasetron - 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.

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 4. The 10 steps of Universal Precautions[35;60]	
1.	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
2.	Psychologic assessment, including risk of addictive disorders
3.	Informed consent
4.	Treatment agreement
5.	Pre-/post-treatment assessment of pain level and function
6.	Appropriate trial of opioid therapy +/- adjunctive medication
7.	Reassessment of pain score and level of function
8.	Regularly assess the "Four As" of pain medicine[a] • Analgesia, Activity, Adverse reactions, and Aberrant behavior
9.	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
10.	Documentation of medical management and of pain management according to state guidelines and requirements for safe prescribing

Gourlay DL, Heit HA, et al. *Pain Med.* 2005;6:107-112.
Gourlay DL, Heit HA. *Pain Med.* 2009;10(suppl 2):S115-S123.
[a]Passik SD, et al. *Clin Ther.* 2004;26:552-561.

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

patient name

date of birth

patient address

patient city, state, ZIP code

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

Rx

prescriber name

prescriber address

prescriber city, state, ZIP code

prescriber phone number

Naloxone HCl 1 mg/mL
2 x 2 mL as pre-filleld Luer-Lock needless syringe
(NDC 76329-3369-1)

Refills: _____

2 x Intranasal Mucosal Atomizing Device (MAD 300)

Refills: _____

For suspected opioid overdose, spray 1mL in each nostril.
Repeat after 3 minutes if no or minimal response.

Pharmacist: Call 1-800-788-7999 to order MAD 300.

prescriber signature

date

Detach for patient

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.

Airway → Rescue breathing

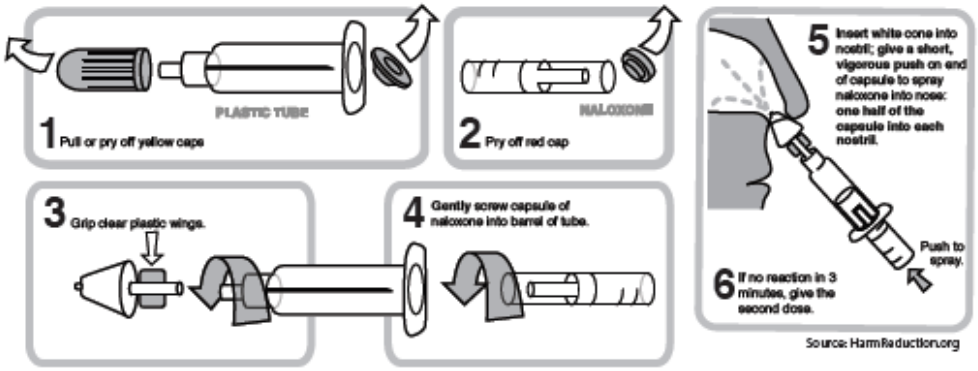
Make sure nothing is inside the person's mouth.

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



Source: HarmReduction.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

POISON Help
1-800-222-1222
AAPCC

v02.12.11

Naloxone Product Comparison

	Injectable (and intranasal-IN) generic		Intranasal branded		Injectable generic[1]		Auto-injector branded	
Sig. (for suspected opioid overdose)	Spray 1 ml (1/2 of syringe) into each nostril. Repeat after 2-3 minutes if no or minimal response.		Spray 0.1 mL into one nostril. Repeat with second device into other nostril after 2-3 minutes if no or minimal response.		Inject 1 mL in shoulder or thigh. Repeat after 2-3 minutes if no or minimal response.		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.	
Ordering information								
How supplied	Box of 10 Luer-Jet™ prefilled glass syringes		Two-pack of single use intranasal devices		Box of 10 or package of 25 single-dose fliptop vials (1 ml)	Case of 25 multi-dose fliptop vials (10 ml)	Two pack of single use auto-injectors + 1 trainer	
Manufacturer	IMS/ Amphastar	Teleflex (off-label IN adapter)	Adapt Pharma		Pfizer, Mylan and West-Ward Pharmaceuticals	Pfizer	kaléo	
Web address	Amphastar.com	Teleflex. com	Narcannasalspray.com		Pfizerinjectables.com Mylan.com West-ward.com	Pfizerinjectables.com	Evzio.com	
Customer service	800-423-4136	866-246-6990	844-462-7226		877-946-7747 (P) 724-514-1800 (M) 800-631-2174 (W)	877-946-7747 (P)	855-773-8946	
NDC	76329-3369-01	DME- no NDC	69547-353-02	69547-212-04	00409-1215-01 (P) 67457-0292-02 (M) 0641-6132-25 (W)	00409-1219-01	60842-030-01	60842-051-01

[1] 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)
[2] This product concentration is not yet currently available. As a result, some of the content is left blank.
[3] 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.
[4] 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

NALOXONE PRICING IN THE COMMUNITY (As of January 2019)					
		naloxone injection (0.4mg/mL)	naloxone prefilled syringe (2 mg/2 mL)	Narcan® nasal spray (4 mg/0.1 mL)	Evzio® auto-injector (2 mg/0.4 mL)
Route of medication		Intramuscular only	Intranasal with atomizer	Intranasal	Intramuscular
Cash Price based on goodrx.com[1]		$12.80 to $21.13*	$20.99 to $36.85	$129.99 to $139.13	>$3,720
CVS Pharmacy[2]		$18.99	$38.99	$95[3]	$2,225.99
Walgreens[4]		NA	$39.99	$135	NA
MassHealth		$3.65†	$3.65†	$3.65†	NA
Fallon Community Health Plan	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
	Hybrid Formulary	Tier 1 *$1*	Tier 1 *$1*	Tier 4 *50% coinsurance‡*	Tier 3; PA *$30*
	NaviCare (Medicare Part D)	Generic available through mail-order	Generic available through mail-order	Generic	NA
AllWays Health Partners §	3 Tier, 4 Tier, 5 Tier, 6 Tier Formulary	Tier 1 or Tier 2	$0	Tier 2 or Tier 3	NA
Tufts	Health RITogether	Tier 1	NA	Tier 2; QL: 2 kits/30 days, 1 kit/Rx	Tier 2; QL: 4 units/30 days, 2 units/Rx; PA
	Health Direct	$0	NA	$0	Tier 3; QL: 4 units/30 days, 2 units/Rx; PA
Blue Cross Blue Shield of MA Standard	Standard 3-Tier Pharmacy Program Formulary	Tier 1	Tier 3	Tier 3	Tier 2
Harvard Pilgrim Health Care	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

IM=intramuscular, IN=intranasal, 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
3. https://cvshealth.com/newsroom/press-releases/cvs-health-expands-efforts-educate-patients-about-naloxone
4. Walgreens Source: 99 Stafford Street, Worcester, MA

Naloxone Standing Order:

- Naloxone is available in Massachusetts without a prescription through a statewide standing order.
- https://www.mass.gov/files/documents/2018/10/18/standing-order-dispensing-naloxone-rescue-kits.pdf

Intranasal administration	Intramuscular injection
Naloxone 4 mg/0.1 mL nasal spray* Directions for use: Administer a single spray of naloxone in one nostril. Repeat after 3 minutes if no or minimal response.	Naloxone 0.4 mg/mL in 1 mL single dose vials* Directions for use: Inject 1 mL IM in shoulder or thigh. Repeat after 3 minutes if no or minimal response.
Naloxone 2 mg/2 mL single-dose Leur jet prefilled syringe*† Directions for use: Spray 1 mL in each nostril. Repeat after 3 minutes if no or minimal response.	Naloxone 2 mg/0.4 mL auto-injector* 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.

*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
- 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/
- Evzio Patient Assistance Program: https://evzio.com/patient/in-chronic-pain/kaleo-cares/
    - US citizens without insurance (commercial, state, or federal) and an annual household income <$100,000

Opioid treatment agreements

UMassMemorial

OPIOID PAIN MEDICATION AGREEMENT

Place name sticker or stamp with card

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…)

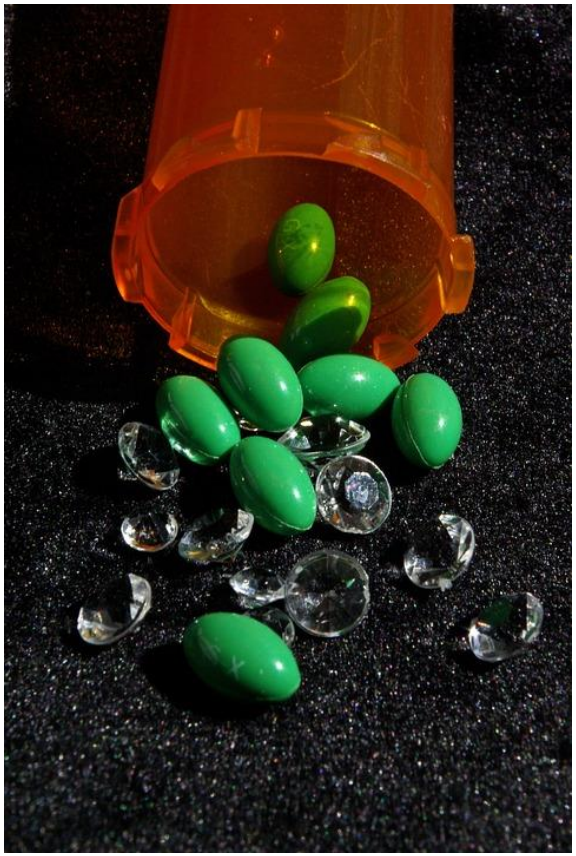
Issues to discuss in opioid agreement

- 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 <u>set level of monitoring to match risk</u>

Adapted from Alford May 2010

Safe opioid storage and disposal

- 70% of people who abuse prescription drugs get them from family or friends.[1]
- 54.4% of respondents asked about their source for nonmedical use of prescription opioid pain relievers reported that they were given the opioid by their friend or relative for free
  - 4.9% reported that their source of opioid pain reliever was “stolen from a friend or relative” [2]
- Improper storage, use, and disposal of prescribed opioids can lead to diversion or accidental poisoning. [3]
- MMS provides a nice summary



Safe opioid storage

- All opioids should be stored in their original packaging inside a locked cabinet, lockbox, or location where others cannot easily access them[4]
  - It is important for the patient to track how much medicine they take and how much is/should be left

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.