



## **Community Guideline on Opioid Dosing for Chronic Non-cancer Pain:**

*An educational aid to improve  
care and safety with opioid therapy*

**2013**

**WVP Health Authority  
and  
Marion-Polk County Medical Society**

You can find this guideline and related tools at [www.wvphealthauthority.org](http://www.wvphealthauthority.org)

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### Synopsis of Guidance

The following guidance was developed through a committee of local practitioners and was facilitated by WVP Health Authority with a goal of providing a comprehensive “tool-kit” to assist providers in the appropriate use of opioids. This guidance is based on the guidelines put in place by the Washington State Medical Directors. The committee that developed this tool for Marion and Polk County providers, made adjustments to ensure that it was applicable to our community and providers. This guidance is not intended as a directive or administrative requirement for local providers.

The guidance supports a maximum limit for patients of 180 Morphine Equivalents per Day, to be lowered to 120 MED in 1 year time. This does not apply to acute pain, cancer pain or end-of life pain. The guidance provides recommended evaluation tools and referral sources for the various stages of opiate use in your patients. It is separated into four distinct sections; Before you Decide to Prescribe, After you Decide to Prescribe, When you Decide to Stop Prescribing and Tools to Evaluate and Monitor your Patients Taking more than 120 MED per day.

Also included are tools to assist in interpretation of Urine Drug Testing Results, taper recommendations and alternative therapies. These may be accessed quickly through the links provided on the “Quick Links to Tools” page.

## Quick Links to Tools

The scope of this guideline is limited to moderate to severe chronic, non-terminal pain. It is NOT intended to apply to:

- a. Acute pain related to recent injury, surgery or illness within the past three months.
- b. Pain due to cancer.
- c. Patients in hospice or who are expected to live less than a year.

**To use the links below, press CTRL key and right click the link with your mouse.**

### Dosing threshold recommendations of this guidance.

This guidance begins with a recommendation to limit the average daily MED (Morphine Equivalent Dose) to 120mg per day. [Click here](#) for details

Tools: [MED Calculator](#)  
[Consult Guidance](#)

**BEFORE you decide to prescribe opioids for chronic pain** (pain lasting more than 3 months.) [Click here](#) for details

1. Attempt non-opioid strategies - [Click here](#) for alternatives
2. Screening for risk factors- [Click here](#) for details and tools
  - a. [Triage guide](#) for risk assessment

**AFTER you decide with the patient to prescribe chronic opioid therapy.** [Click here](#) for details

1. Ongoing screening and monitoring- [Click here](#) for details and tools
2. Ongoing assessment of function and pain- [Click here](#) for details and tools
3. Ongoing assessment of effects of chronic opioid therapy- [Click here](#) for details and tools
  - a. Urine Drug Testing recommendations and interpretation- [Click here](#) for details and tools
4. Support services
  - a. Specialty consult- [Click here](#) for details and tools

**When you decide to STOP opioid therapy.** [Click here](#) for details.

1. Tapering recommendations- [Click here](#) for details and tools
2. Identification of behavior issues during tapering- [Click here](#) for details and tools

**Optimizing treatment when patients are taking more than 120 mg MED per day.** [Click here](#) for details.

# Community Guideline on Opioid Dosing for Chronic Non-cancer Pain

## WVP Health Authority

6-17-2013 Version 1.21 Edited by Steve Tackett-Nelson MD

### Introduction

This guideline was originally published in March 2007 as an educational pilot sponsored by the Washington State Agency Medical Directors' Group (AMDG)<sup>1</sup>. The original guideline and an updated version Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain were developed in collaboration with actively practicing providers with extensive experience in the evaluation and treatment of patients with chronic pain. In early 2013 the Washington guideline was reviewed and adapted by a workgroup in Marion County to reflect Oregon regulations, practice patterns and resources. It is intended as a resource for primary care providers treating patients with chronic non-cancer pain. It does not apply to the treatment of acute pain, cancer pain, or end-of-life (hospice) care. This guideline is based on best practice recommendations from medical science as tempered by the realities of existing community practice patterns in Marion and Polk Counties as of 2013. It is intended only as a guideline for practitioners and is not intended as a set of prescriptive rules to be enforced by any public or private organization.

Providers prescribing opioids know there is a delicate balance between the under-treatment and over-treatment of chronic non-cancer pain. This guideline provides information on the scope of the challenge, recommendations for prudent prescribing and monitoring, advice on how to get consultative assistance, and resources for educating patients.

For most types of chronic pain opioid analgesics are not the main treatment of choice, though they can be helpful in limited and adjunctive roles. There may also be a lack of thorough and consistent evaluation of the individual risks and benefits for patients before they are started on chronic opioid analgesia. Customary and appropriate use of opioids for acute pain relief often transitions gradually and almost imperceptibly into less beneficial chronic pain management as an acute medical situation changes to a chronic pain syndrome.

Excesses can also occur in the opposite direction. Patients with pain and serious co-occurring medical illnesses are sometimes abruptly taken off of established opioid pain medications or terminated altogether from a practitioner due to infractions of narcotic contracts or abnormalities in urine drug screens. This frequently leaves such a patient feeling hostile and suspicious toward medical providers in general, making things much more difficult for the next physician who takes over the case. Also, if the abnormality/infraction was due to a substance abuse problem, firing the patient is a missed opportunity to intervene and treat the substance use disorder. Although opioid withdrawal is quite unpleasant and usually harmless for young and otherwise healthy individuals, for elderly or medically fragile patients it can lead to significant morbidity, unnecessary hospitalization, and occasionally death.

As for many other conditions, guidelines are becoming the standard of care for the management of chronic pain. Historically, public and medical opinion regarding the use of opioids has tended to swing from menace to panacea and back every decade or so. The Washington State Agency Medical Directors' Group (AMDG)<sup>1</sup> wrote in 2006 and updated in 2010 the guideline from which this document has been adapted. A stable evidence-based guideline could significantly reduce the extent to which standards of rational medical practice are colored by public sentiment and rare but sensational cases.

This guideline is intended to serve multiple functions:

1. Provide concise, well-researched and relevant information helpful to advise practitioners about opioid prescribing practices and alternative treatments, improving patient well-being and function.
2. Encourage more uniform evaluation and prescribing practices throughout the community. It should reduce patient incentives for “doctor shopping” and decrease patient “churn” through practices, lowering overhead and improving care.
3. Give practitioners more information, options and support around the management of chronic pain, therefore lowering the rate of practitioner burn-out related to pain patients.

## **Opioid Assistance Committee**

To support the development and implementation of this guideline, an Opioid Assistance Committee (OAC) will be established in Marion and Polk Counties as a multidisciplinary advisory and consultative body operating under the auspices of the Marion-Polk County Medical Society (MPCMS). It shall be composed of 4 to 7 local practitioners encompassing a full range of expertise including, but not limited to, primary care, chronic pain treatment, addictionology and psychiatry. OAC membership shall be inclusive of the local provider demographic. Regular meetings will be held at least quarterly, but no more often than twice per month. Special meetings may be called at any time to deal with emergent situations. The OAC may call on further specialists, consultants and advisors as needed to assist in dealing with particularly complex cases.

The OAC has no administrative jurisdiction over the local providers. The primary role of the OAC shall be to assist practitioners to make decisions in difficult situations regarding the use of opioids for chronic non-cancer pain management by providing consultation, advice and education to practitioners. Specific duties include practitioner request for consultation, review of guidelines and community and provider outreach and education.

The OAC shall also be responsible for a biennial review and revision of this guideline to ensure the incorporation of advances in the art and science of pain medicine and to maintain suitability for the practice environment in Marion and Polk Counties. Interim recommendations and revisions may be made as needed.

Additionally, the OAC shall assist in assessing the educational needs of local practitioners regarding the diagnosis and management of chronic non-cancer pain, and assist in arranging educational activities to support local practitioners in managing such pain. Because management of chronic pain involves elements of primary care, mental health, and addictions treatment, the OAC shall endeavor to bring about better communication and closer working relationships between local providers in these areas.

## Part I - Guidelines for initiating, transitioning, and maintaining oral opioids for chronic non-cancer pain

Part I of the dosing guideline will assist primary care providers in prescribing opioids for adults in a safe and effective manner when:

- Instituting or transitioning opioid therapy from acute to chronic non-cancer pain;
- Assessing and monitoring opioid therapy for chronic non-cancer pain; and
- Tapering or discontinuing opioids if a trial fails to yield improvements in function and pain. An opioid trial is a period of time during which the effectiveness of using opioids is tested to see if goals of increased functionality and decreased pain are met. A trial should include specific goals and should occur prior to starting long-acting opioids. If goals are not met, the trial should be discontinued and an alternative treatment approach taken<sup>9</sup>.

Managing chronic pain and providing appropriate opioid therapy is a challenging aspect of both primary care and specialty care practices. That is why it is critical for prescribers to be very conscious of the risks, and intentional about the treatment plan when prescribing these drugs. Best practice treatment requires attention to a number of special issues.

### Dosing threshold for pain consultation

The hallmark of this guideline is a recommendation to **limit the average daily morphine equivalent dose (MED) to 120mg** unless *either* the patient demonstrates improvement in function and pain *or* a consultation is obtained from a pain management expert with recommendations supporting an average daily dose greater than 120mg MED. A recent cohort study supports the 120mg MED dosing threshold. It “provides the first estimates that directly link receipt of medically prescribed opioids to overdose risk and suggests that overdose risk is elevated in chronic non-cancer pain patients receiving medically prescribed opioids, particularly in patients receiving higher doses”<sup>10</sup>. Patients receiving 100mg or more per day MED had a 9-fold increase in overdose risk. Most overdoses were medically serious, and 12% were fatal.

**Transitional Ceiling** As an interim transitional measure, for the first twelve months after this guideline takes effect the recommended total opioid dose of short-acting plus long-acting opioid medications should be no more than 180 milligrams morphine equivalent daily (MED). After the transition period, this recommendation should be lowered to 120 mg MED day. Doses higher than the recommended ceiling may be effective and well-tolerated in certain cases, and practitioners are recommended to seek consultation from a pain specialist or the Opioid Assistance Committee regarding doses above the ceiling.

High dose opioid therapy can be unsafe and often provides no therapeutic advantage. Higher strength pain medicines may be associated with poorer functional outcomes than lower strength opioids<sup>11,12</sup>. Providers must pay attention to the development of tolerance and adverse outcomes of chronic opioid use<sup>13</sup>. Opioids become particularly dangerous when used in conjunction with other medications — sedative-hypnotics, benzodiazepines, anti-depressants or muscle relaxants — or with alcohol. Some health conditions like sleep apnea, chronic obstructive pulmonary disease or congestive heart failure, may also place patients at increased risk for opioid toxicity.

This guideline endorses and encourages the use of the Washington State online calculator for determining a patient’s daily MED, *and* a calculator for when the patient needs an opioid taper plan.

(<http://agencymeddirectors.wa.gov/mobile.html>) For patients already on doses higher than 120mg MED see Part III of this guideline for recommendations to optimize treatment. Resources for calculating MED when patients are on one or more opioids can be found in [Appendix A](#).

**Methadone Exception** Due to the past state and local history of extensive reliance on methadone for the management of chronic pain, patients may be taking methadone alone or in combination with other opioids who are stable and functional on current treatment. For patients currently maintained on methadone at the time this guideline becomes effective, with or without other opioid medications in addition, an exception is made to the recommendation that such patients should have their medications reviewed by the Opioid Assistance Committee if their dose exceeds the recommended ceiling. Practitioners caring for such patients are encouraged to be aware of the recommendations in Part III of this guideline, specifically directed at optimizing treatment when opioid doses are greater than 120 mg MED/day. This exception should not be taken as reflecting best practice guidelines or any pharmacological dose equivalence between methadone and other opioids.

Current available medical evidence supports the following recommendations:

- The total daily dose of opioids should not be increased above 120mg MED without either the patient demonstrating improvement in function and pain or first obtaining a consultation from a practitioner qualified in chronic pain management. \*[List of providers](#)
- Risks substantially increase at doses at or above 100mg<sup>10</sup>, so early attention to the 120mg MED benchmark dose is worthwhile.
- Safety and effectiveness of opioid therapy for chronic non-cancer pain should be routinely evaluated by the prescriber.
- Assessing the effectiveness of opioid therapy should include tracking and documenting both functional improvement and pain relief.
- If there is evidence of frequent adverse effects or lack of response to an opioid trial, a consultation should be considered. Follow the guidance for seeking consultative assistance as described in Table 1.

Table 1. Guidance for Seeking Consultative Assistance

<ul style="list-style-type: none"> <li>• Prescribing opioid doses <b>up to</b> 120mg MED/day (Cumulative daily dose when using one or more opioids. See Table 4 in <a href="#">Appendix A</a> for specific opioid thresholds.)</li> <li>• In general, the total daily dose of opioid should not exceed 120 mg oral MED.</li> <li>• No assistance from a pain management consultant is needed if the prescriber is documenting sustained improvement in both function and pain.</li> <li>• Risks substantially increase at doses at or above 100mg<sup>10</sup>, early attention to this benchmark dose is worthwhile.</li> </ul>	
<p><b>Consider</b> getting consultation if there is lack of response or serious adverse effects in order to address:</p> <ul style="list-style-type: none"> <li>• Evidence of undiagnosed conditions;</li> <li>• Presence of significant psychological condition affecting treatment; and</li> <li>• Potential alternative treatments to reduce or discontinue use of opioids</li> </ul>	<p><b>Before exceeding</b> 120mg MED/day threshold, seek out a pain management consultant to address:</p> <ul style="list-style-type: none"> <li>• Potential alternative treatments to opioids;</li> <li>• Risk and benefit of a possible trial with opioid dose above 120mg MED/day;</li> <li>• Most appropriate way to document improvement in function and pain; and</li> <li>• Possible need for consultation from other specialists</li> </ul>

Figure 1. Morphine Equivalent Dose Calculation

For patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose (see [Table 5 in Appendix A](#) for MEDs of selected medications). For example, if a patient takes six hydrocodone 5mg / acetaminophen 500mg and two 20mg oxycodone extended release tablets per day, the cumulative dose may be calculated as follows:

- 1) Hydrocodone 5mg x 6 tablets per day = 30mg per day.
- 2) Using the Equianalgesic Dose table in Appendix A, 30mg Hydrocodone = 30mg morphine equivalents.
- 3) Oxycodone 20mg x 2 tablets per day = 40mg per day.
- 4) Per Equianalgesic Dose table, 20mg oxycodone = 30mg morphine so 40mg oxycodone = 60mg morphine equivalents.

5) Cumulative dose is 30mg + 60mg = 90mg morphine equivalents per day.

An electronic opioid dose calculator can be downloaded at: [www.agencymeddirectors.wa.gov/guidelines.asp](http://www.agencymeddirectors.wa.gov/guidelines.asp)

## **BEFORE you decide to prescribe opioids for chronic pain**

Acute pain is self-limiting and lasts from a few days to a few weeks following trauma or surgery. Chronic pain can result from a number of conditions, diseases or injuries and is generally considered as pain lasting more than 3 months. Because of the potentially serious adverse long-term effects of opioids, it is critical that the prescriber comprehensively assess the risks and benefits of treatment prior to deciding whether to prescribe opioids. Consider opioid therapy when:

- Other physical, behavioral and non-opioid measures have failed (e.g. physical therapy, cognitive behavioral therapy, NSAIDs, antidepressants, antiepileptics), and
- The patient has demonstrated sustained improvement in function and pain levels in previous opioid trial, and
- The patient has no relative contraindication to the use of opioids (e.g. current or past alcohol or other substance abuse, including tobacco.<sup>14,15</sup>).

Many patients treated with high doses of opioids for chronic pain could have better daily functioning and a longer life expectancy with a different treatment approach. Better results are often obtained from a balanced combination of different treatment modalities and medications tailored to the patient's individual situation rather than looking for a single solution. It initially takes longer to try a variety of different treatments and find a suitable pain-management plan for each individual patient but in the long run this strategy often proves easier to maintain as well as being safer and leading to better functional outcomes.

### ***Non-Opioid Strategies***

A partial list follows of non-opioid strategies for chronic pain management. In most cases one of these strategies or a combination of several will either work better than opioids or add considerable effectiveness to opioids and provide good pain management with a lower opioid dosage. Before managing someone with long-term opioid analgesia, this guide recommends trialing three or more of these possibilities first.

#### **Adjunctive or Alternative Treatments**

1. Antidepressants – Amitriptyline has been a first-line treatment for neuropathic pain for many years. Frequently helpful agents include: duloxetine, venlafaxine, amitriptyline, nortriptyline and other tricyclic antidepressants.<sup>53</sup> These are often better than opioids for chronic neuropathic pain such as diabetic neuropathy and also in chronic low back pain.<sup>52</sup> They are also useful for radicular pain, fibromyalgia and non-specific low back pain. The tricyclic antidepressants also promote sleep, reduce nightmares, and treat irritable bowel symptoms. Amitriptyline should be used as part of the treatment of neuropathic pain or fibromyalgia, but only a minority of patients will achieve satisfactory pain relief. Limited information suggests that failure with one antidepressant does not mean failure with all.<sup>51</sup>
2. Milnacipran - A serotonin-norepinephrine reuptake inhibitor similarly approved for the treatment of fibromyalgia, but has not shown efficacy in treating depression. Chronic pain often is coupled with depressing events such as losing one's job, home, significant other, strength and ability to perform or enjoy usual activities. When one is depressed, even minor psychosocial and physical injuries are felt intensely. Quite frequently a mutually reinforcing cycle of pain and depression becomes established and many

patients with chronic pain attribute their depression solely to their pain, but have improvement in energy and function with adequate antidepressant treatment

3. Anti-seizure medications – Gabapentin is approved for neuropathic pain and is also often helpful for fibromyalgia pain complicated by anxiety. It is safer than benzodiazepines, particularly in combination with opioids. Pregabalin is similar in efficacy, perhaps a bit easier to titrate, but under patent protection until 2018, thus more expensive. Carbamazepine has long been effective for relief of or trigeminal neuralgia and is often useful for other types of neuropathic pain.
4. Muscle relaxants – Some commonly used agents include baclofen, cyclobenzaprine, methocarbamol, tizanidine and metaxalone. These can sometimes be extremely helpful for back or neck pain. If examination of the painful area reveals palpable bands of muscles in spasm, a trial of muscle relaxants is usually worthwhile. While somewhat sedating, these are not controlled substances and patients typically only self-adjust doses to a limited extent. It is worthwhile to give several different agents month-long trials, and adjust dosing schedules to maximize relief while minimizing daytime sedation. For a month at a time Baclofen may have some analgesic activity in addition to relaxing skeletal muscle. Try two or three different ones before deciding that muscle relaxants are not helpful.
5. Avoid carisoprodol (SOMA) - This is habit-forming and is a controlled substance in Oregon. Its pharmacology is similar to meprobamate and barbiturates and abrupt discontinuation can lead to seizures. It has anti-anxiety as well as muscle relaxant properties, similar to benzodiazepines, but offers no advantage over them in treating muscle spasms or anxiety.
6. Triptans - For migraine disease.
7. Adequate sedation at bedtime - Pain is often worse in the evening, and sound sleep is restorative. Avoid controlled substances (benzodiazepines) in combination with opioids. Useful medications include trazodone, hydroxyzine, gabapentin, doxepin (very low dose), amitriptyline, and imipramine. Most muscle relaxants have sedative side effects, and if dosed at bedtime or a few hours before can often be made to work well for bedtime sedation.
8. Movement Therapy (a.k.a. “exercise”) – This is the treatment of choice for fibromyalgia.
9. Smoking cessation – This is very helpful for chronic non-radicular back pain.<sup>56</sup>
10. Lifestyle adaptations – Patients can very often resume meaningful activities if they stop waiting for the pain to go away. Limiting, planning and pacing activity are three of the most useful strategies for adapting to chronic pain.
11. Improved sleep hygiene – In addition to sedating medications, establishing a sleep-promoting bedtime routine helps. Exercise earlier in the day. Valerian, or chamomile can promote sleep. Avoid alcohol in the evening, can cause early morning (3 or 4 am) awakening.
12. Dietary modifications – Helpful with celiac disease, GERD, non-specific abdominal pain.
13. Mental health evaluation and treatment for co-occurring disorders – Chronic pain is very commonly associated with some combination of childhood abuse or neglect, depression and post-traumatic stress disorder. Talk therapy or 12-step both work as well as psych meds, often better in combination with medications.
14. Chemical dependency evaluation and treatment as needed – Addicts have pain, and pain meds can cause addiction. Each case is a little different. Get early consultation from an addiction or mental health specialist. [\\*List of providers](#)
15. Stress Management and Emotional Coping Skills – Behavioral pain treatment programs can teach patients psychological management techniques especially devised for ongoing chronic pain management.<sup>54, 55</sup>
16. Transcutaneous Electrical Nerve Stimulation – Can be useful, consider for localized pain.
17. Acupuncture – There is low to moderate-level evidence that compared with no treatment and standard therapy, acupuncture improves pain and stiffness in people with fibromyalgia. There is moderate-level evidence that the effect of acupuncture does not differ from sham acupuncture in reducing pain or fatigue,

or improving sleep or global well-being. Electro-acupuncture (EA) is probably better than manual acupuncture (MA) for pain and stiffness reduction and improvement of global well-being, sleep and fatigue. The effect lasts up to one month, but is not maintained at six months follow-up.<sup>50</sup>

18. 12-step programs – Some patients find this quite helpful, regarding pain as something that they are powerless over and giving up their attempts to control pain to their higher power.

19. Consultation by a specialist or interdisciplinary group - Evaluation and/or treatment of patients who are particularly complex, high risk, or unresponsive to ordinary treatment measures. \*[List of providers](#)

## Screening

Like all treatments, use of opioids needs to be evaluated on a case-by-case basis, balancing risks and benefits. Chronic opioid therapy (e.g., more than 90 days of therapy) should only be initiated on the basis of an explicit decision and agreement between prescriber and patient. The patient needs to be informed of the benefits and risks of opioid therapy of indefinite duration. Sample agreements for the prescriber and patient are in [Appendix G](#). Screening for potential comorbidities and risk factors is crucial so that anticipated risk can be monitored accordingly. Depression and anxiety disorders are frequently associated with the use of opioids<sup>16</sup>. Current and past substance abuse disorders appear to increase the risks of chronic opioid therapy<sup>17-20</sup>.

### Risk Factors (Relative Contraindications) for Chronic Opioid Analgesic Therapy

- Pain complaints have not been fully evaluated/diagnosed to find a treatable cause.
- Non-opioid treatments have not been exhausted.
- History of suicide attempt in past 2 years.
- History of suicide attempt with pills anytime.
- Patient currently in methadone maintenance.
- No functional improvement noted after opioid trial.
- Active substance abuse per DSM criteria or ASAM evaluation.
- An undertreated behavioral health condition exists, defined as PHQ 9 score > 15 and:
  - No active treatment for an active diagnosis.
  - No engagement with behavioral health if referred.
  - Diagnosis not clear or well-established.
- History of misuse/overuse :
  - Receiving multiple prescriptions from multiple sites/providers. (Check OPDMP)
  - Increased ED use for obtaining narcotics/opioids.
  - Previous narcotic agreement violation or dismissal.
- History of diversion :
  - High Risk: recent, large quantities, repeated, for profit.
  - Lower Risk: long ago, small quantity, only a few times, to a friend or relative with an injury.

Risk factors operate differently in different patients. Recency, frequency and severity all modulate the importance of information about a risk factor. (A former cocaine user with a wife, a job and 15 years in narcotics anonymous is a much lower risk than a heroin user with three months clean, even though both are “recovering addicts.”) Most risk factors should be treated as relative rather than absolute contraindications. The clear presence of one risk

factor or likely presence of two or more does not rule out successful use of opioids, but indicates the need for a higher level of caution and vigilance.

## Evaluation

If substantial risk is identified through screening, extreme caution should be used and a specialty consultation (e.g. addiction or mental health specialist) is strongly encouraged. In such cases, a baseline risk assessment using the following tools should be performed and documented in the record:

2. The CAGE-AID to screen for alcohol or drug problems. (Should be done on all patients on opioids or not.)
3. The Opioid Risk Tool (ORT) to screen for risk of opioid addiction. Good alternatives are the SOAPP (Screener and Opioid Assessment for Patients with Pain), or SISAP (Screening Instrument for Substance Abuse Potential).
4. The PHQ-9 to screen for depression and rate severity
5. A baseline urine drug test, including ethyl glucuronide or ethyl sulfate if undisclosed alcohol use is suspected.
6. Check the patient’s controlled medication history through the Oregon Prescription Drug Monitoring Program.
7. A baseline assessment of function and pain with the 2 item Graded Chronic Pain Scale ([Appendix C](#))

## Triage Guide Gourlay et al 2005

This table provides criteria for assigning a risk level and determining next steps for your patient.

Risk Level	Characteristics	Management
Low	<ul style="list-style-type: none"> <li>• No history of substance abuse; minimal if any risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• Can be managed by primary care physician (PCP)</li> <li>• If aberrant behaviors are observed, consider increasing risk category</li> </ul>
Medium	<ul style="list-style-type: none"> <li>• History of substance abuse (not Rx opioid abuse); significant risk factors*</li> <li>• Patient previously assigned to low-risk category exhibits aberrant behaviors**</li> </ul>	<ul style="list-style-type: none"> <li>• PCP co-manages with addiction and/or pain specialists. <a href="#">Providers</a></li> <li>• If aberrant behaviors are observed or persist, consider assigning to high risk category</li> </ul>
High	<ul style="list-style-type: none"> <li>• Active substance abuse problem; major psychiatric illness, history of prescription opioid abuse</li> <li>• Patient previously assigned to medium-risk category exhibits aberrant behaviors**</li> </ul>	<ul style="list-style-type: none"> <li>• Opioids may not be appropriate in the primary care setting, if at all</li> <li>• Refer patients to specialists in management of patients with comorbid pain and addictive disorders</li> <li>• Continue to manage patient's medical care and monitor specialized care</li> </ul>

\* Risk factors for prescription opioid abuse include active substance abuse, past substance abuse, family history of substance abuse, history of prescription drug abuse, current or past mental health disorder (personal or family), younger age, and criminal activity. None of these risks are absolute, and opioid addiction may occur in their absence.

\*\* Aberrant behaviors include: Deteriorating personal appearance; worsening of hygiene; appearing sedated, sleepy, confused or intoxicated; expressing concerns about addiction; rapid mood swings that occur the same time every day; lack of interest in self-care for illnesses; involved in accidents, especially MVAs, conflict with family; insists on certain medications by name; takes pain meds in response to emotional or situational stress; frequent requests for early refills/runs out early; reports lost stolen prescriptions; obtaining prescriptions from multiple doctors; expresses concern about continued availability of opioid medication; hoarding/stockpiling medication; predominant issue of interest at office visits is pain medication; reports minimal or inadequate

relief from medication; buys opioids on the street; misrepresents symptoms or medication use; family/friends/coworkers express concern about opioid use.

## **AFTER you decide with the patient to prescribe chronic opioid therapy**

When instituting chronic opioid therapy, both prescriber and patient should discuss and agree on all of the following:

- Risks and benefits of opioid therapy supported by an opioid agreement. Sample agreements can be found in [Appendix G](#).
- Treatment goals, which must include improvements in both function and pain while monitoring for, and minimizing, adverse effects.
- Expectation for routine urine drug testing.
- A follow-up plan with specific time intervals to monitor treatment.

Once a decision is made to institute chronic opioid therapy, the prescriber is responsible for routinely monitoring the safety and effectiveness of ongoing treatment.

## **Principles for safely prescribing chronic opioid therapy**

- Single prescriber
- Single pharmacy
- Patient and prescriber sign opioid agreement
- Lowest possible effective dose should be used
- Recommend prescribing in 28-day cycles so that patients always come up for refills on the same day of the week, making it easy to spot early refill requests
- Be cautious when using opioids with conditions that may potentiate opioid adverse effects; including COPD, CHF, sleep apnea, alcohol or substance abuse, elderly, or history of renal or hepatic dysfunction
- Do not combine opioids with sedative-hypnotics, benzodiazepines or barbiturates for chronic non-cancer pain unless there is a specific medical and/or psychiatric indication for the combination and increased monitoring is initiated
- Routinely assess function and pain status, see [Tools for assessing function and pain](#).
- Monitor for medication misuse, see [Reasons to discontinue opioids or refer for addiction management](#).
- Random urine drug testing to objectively assure compliance, see [Urine drug testing](#).

Special care should be taken when prescribing methadone for chronic pain. One helpful article for clinicians is: *Methadone Treatment for Pain States*<sup>21</sup>. The Marion County Health Department also has a methadone program with a separate clinical track for patients whose opioid problems revolve mainly around prescription opioids rather than street drugs. See [Appendix H, Additional Resources](#).

## **Screening and monitoring your patient**

Several screening tools are available to help assess risk for aberrant drug-related behavior, current or former substance abuse, and mental health disorders. High risk does not necessarily contraindicate the use of opioids but additional monitoring is indicated whenever risk is increased for any reason. Additional monitoring may include increased frequency of reassessment of pain, function, and aberrant behaviors, decreased number of doses prescribed, and increased frequency of UDT. Based on a review of the literature and the consensus of the advisory committee, the following three easy-to-use tools are recommended for their clinical utility in screening opioid therapy patients. (The following screening tools, and others are available in [Appendix B](#).)

### **Opioid Risk Tool (ORT)<sup>22</sup>**

- Purpose: to assess a patient's risk of opioid addiction
- Brief, 5-question survey
- Easily accessible
- Currently, there is no screening tool for risk of opioid addiction that has strong psychometric evidence.

### **CAGE-AID<sup>23-25</sup>**

- Purpose: to screen for alcohol or drug problems
- Brief, 4 question-survey
- Easily accessible
- Relatively strong psychometric evidence base

### **PHQ-9<sup>26</sup>**

- Purpose: to screen for, diagnose, and monitor depression severity
- Brief, 9-item questionnaire
- Easily accessible
- Superior psychometric evidence base

## **Tools for assessing function and pain**

The key to effective opioid therapy for chronic non-cancer pain is to achieve sustained improvement in pain and physical function<sup>27,28</sup>. Tracking function and pain is critical in determining the patient's ongoing response to opioids and whether any improvement is consistent with potential changes in opioid dosing. Critical to this guideline, if function and pain do not substantially improve with opioid dose increases, then significant tolerance to opioids may be developing and consultative assistance is strongly recommended.

An assessment of function and pain should consistently measure the same elements to adequately determine the degree of progress. While there is no universally accepted tool to assess opioid therapy's impact on function and pain, several are available and listed in [Appendix C](#). In particular, the AMDG recommends using the two item Graded Chronic Pain Scale<sup>29,30</sup> ([Figure 2](#)) as an ongoing and rapid method to easily track function and pain in the medical record. See [Appendix C](#) for instructions on scoring and interpretation.

Other functional assessment tools that may be helpful in monitoring your patient's progress include, but are not limited to:

- SF36 Health Survey - [www.rand.org/health/surveys\\_tools/mos/mos\\_core\\_36item.html](http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html)
- Brief Pain Inventory - [www.ohsu.edu/ahec/pain/paininventory.pdf](http://www.ohsu.edu/ahec/pain/paininventory.pdf)
- *QuickDash* - for musculoskeletal disorders of the upper extremities  
[www.dash.iwh.on.ca/outcome\\_quick.htm](http://www.dash.iwh.on.ca/outcome_quick.htm)
- Quality of Life Scale - [www.uic.edu/orgs/qli/questionnaires/questionnairehome.htm](http://www.uic.edu/orgs/qli/questionnaires/questionnairehome.htm)
- Oswestry Disability Index - [www.workcover.com/public/download.aspx?id=794&str=disability index oswestry](http://www.workcover.com/public/download.aspx?id=794&str=disability%20index%20oswestry)
- Neck Disability Index - [www.workcover.com/public/download.aspx?id=792&str=disability index neck](http://www.workcover.com/public/download.aspx?id=792&str=disability%20index%20neck)
- Short Musculoskeletal Function Assessment - See: [www.ejbjournals.org/cgi/reprint/81/9/1245](http://www.ejbjournals.org/cgi/reprint/81/9/1245)

These instruments have all been independently validated and may be available at websites other than those listed above.

## Assessing effects of chronic opioid therapy

Chronic opioid therapy is associated with the development of tolerance to its analgesic effects<sup>31,32</sup>. Evidence is accumulating that opioid therapy may also paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia<sup>33-35</sup>. Thus, increasing opioid doses may not improve function and pain control.

The prescriber should assess the risks and benefits of the patient's current opioid therapy. This assessment should include:

- Function and pain status. See [Tools for assessing function and pain](#).
- Possible adverse effects of current opioid doses.
- Potential psychiatric disorders affecting treatment.
- Possible drug combinations or conditions that may potentiate opioid adverse effects (such as COPD, CHF, sleep apnea, current or past alcohol or substance abuse, advanced age, or history of renal or hepatic dysfunction); and
- Any relative contraindication to the use of opioids (active alcohol or other substance abuse, including nicotine<sup>14,15</sup>). See [Urine drug testing](#)

If function and pain do not improve after a sufficient opioid trial, consider discontinuing opioids. See [Tapering or Discontinuing Opioids](#). When there is evidence of significant adverse effects from opioid therapy, the provider should reduce the opioid dose and reassess the patient's status.

Otherwise, if no reasons for dose reduction or discontinuation are identified, and the prescriber feels (with support of validated measures of function and pain) that the patient is benefiting from current therapy, continuation can be appropriate. Ongoing therapy, however, entails ongoing assessment. The screening described above should be done on a regular basis to assess progression of therapy as the patient's condition changes over time.

<p>Figure 2. Graded Chronic Pain Scale</p> <p><b>Pain intensity and interference</b></p> <p><b>In the last month</b>, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [<i>That is, your usual pain at times you were in pain.</i>]</p> <p><b>No Pain</b> <span style="float: right;"><b>Pain as bad as pain could be</b></span></p> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr>											0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10											
<p><b>In the last month</b>, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?</p> <p><b>No interference</b> <span style="float: right;"><b>Unable to carry on any activities</b></span></p> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr>											0	1	2	3	4	5	6	7	8	9	10
0	1	2	3	4	5	6	7	8	9	10											

## Urine drug testing (UDT)

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse, and verify compliance with treatment. When used with an appropriate level of understanding, UDT can improve the prescriber’s ability to safely and appropriately manage opioid therapy. See [Appendix D](#).

Urine drug testing is an important part of the baseline risk assessment, which prescribers should perform on all candidates for chronic opioid therapy. See [Before you decide to prescribe opioids for chronic pain](#). This baseline UDT should be performed on all transferring patients who are already using opioids and for those patients who you are considering for chronic opioid therapy (e.g. third opioid prescription or >6 weeks after an acute injury). Prior to testing, the prescriber should inform the patient of the reason for testing, the expectation of random repeat testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify drug testing for individual circumstances and more accurately interpret the results.

After opioid therapy has been initiated, the prescriber should randomly repeat testing at the approximate frequency determined by the patient’s risk category based on the ORT or similar screening tools. See [Table 2](#). It is a good practice to also check the patient’s report from the Oregon Prescription Drug Monitoring Program online whenever a UDS is done. Some practitioners routinely check the OPDMP at every appointment.

Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. Information from third parties, such as family and friends, can be helpful in evaluating behavior. Opioid prescribing should be avoided in patients with active alcohol or other substance abuse. Extreme caution should be used, and a consultation with an addiction specialist is strongly encouraged, prior to prescribing opioids for patients with a history of alcohol or other substance abuse.

Table 2. Recommended Frequency of UDT

Risk Category	Recommended UDT Frequency
Low Risk	Periodic (e.g. up to 1/year)
Moderate Risk	Regular (e.g. up to 2/year)
High Risk <b>or</b> opioid doses >120 mg MED/d	Frequent (e.g. up to 3–4/year)
Aberrant Behavior (lost prescriptions, multiple early refill requests, multiple prescribers, unauthorized dose escalation, apparent intoxication etc. See list on page 6.)	At time of visit (Address aberrant behaviors in person, not by telephone)

### Methods of testing

There is no standard UDT that is suitable for all purposes and settings<sup>36</sup>. Currently, two main types of UDT are available:

- Immunoassay drug testing (initial drug test or screen) – based in a lab or office (point-of-care).
- High performance chromatography/mass spectrometry (confirmatory drug test) – available only through a laboratory

Immunoassays are the most common method of testing and can be performed either in a laboratory or at the point-of-care. These tests detect the presence or absence of a drug or drug class according to a predetermined cutoff threshold.

The advantages of immunoassays are their ability to concurrently test for multiple drug classes, provide rapid results and guide appropriate utilization of confirmatory testing. However, immunoassays can cross-react with

other drugs and vary in sensitivity and specificity. Thus, unexpected immunoassay results should be interpreted with caution and verified by confirmatory testing.

If verification or identification of a specific drug and/or metabolite(s) is needed, then confirmatory testing is recommended. Laboratory-based confirmation uses gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) to identify a drug or confirm an immunoassay result.

**Drugs or drug classes to test**

The NIDA 5 (National Institute on Drug Abuse) was established for workplace drug testing and is federally regulated. However, it does not test for many commonly prescribed or abused drugs such as benzodiazepines and semi-synthetic or synthetic opioids, which may be important in compliance testing. Thus, it may be more useful to order an expanded urine drug panel to include any of the drugs listed below in addition to drugs you are prescribing:

<ul style="list-style-type: none"><li>• Cannabinoids</li><li>• Cocaine</li><li>• Amphetamines</li><li>• Opioids</li><li>• Benzodiazepines</li></ul>	<ul style="list-style-type: none"><li>• Alcohol</li><li>• Barbiturates</li><li>• Oxycodone</li><li>• Methadone</li><li>• Fentanyl</li></ul>
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**Interpreting results**

Interpreting UDT results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. When the immunoassay result is unexpected and the patient does not acknowledge or credibly explain the result, a confirmatory test using either GC/MS or LC/MS/MS should be ordered. The presence of cannabis or metabolites may be an indicator of the patient’s risk category. Some providers adopt a “don’t ask, don’t tell” policy, and request the lab to remove marijuana from the UDT so that positive results are not seen. This is a complex issue. Marijuana is currently classified as a Schedule I drug by the DEA. For that reason, many providers will not prescribe opioids to patients using cannabis. Other providers act in reference to the Oregon medical marijuana law and feel comfortable prescribing opioids to some cannabis users. Due the conflict between state and federal regulations and the resultant legal bind into which practitioners are placed, this guideline intentionally and pointedly takes no position and makes no recommendation regarding cannabinoids. Individual prescribers and practices should have an office policy, discuss it with patients, and adjust UDS monitoring accordingly.

If the patient tested negative for prescribed opioids and if confirmatory testing substantiates a “red flag” result, see [Table 3](#), the prescriber should consider a controlled taper or stop prescribing opioids immediately. Prescriber may also consider getting consultation or referral to an addiction specialist or drug treatment program, depending on the circumstances.

<p><b>Table 3. Red Flag Results</b></p> <ul style="list-style-type: none"><li>Negative for opioid(s) you prescribed</li><li>Positive for amphetamine or methamphetamine</li><li>Positive for cocaine or metabolites</li><li>Positive for drug (benzodiazepines, opioids, etc) you did not prescribe or know of</li><li>Positive for alcohol (or alcohol metabolites, if patient has been told not to drink)</li></ul>
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Contact your local laboratory director, toxicologist or certified Medical Review Officer (MRO) for questions about drug testing or results. To locate a MRO in your area, submit a search at the following website: [www.aamro.com/registry\\_search.html](http://www.aamro.com/registry_search.html). If a point-of-care device is used, contact technical support from the manufacturer for questions.

## **Specialty consultation**

Specialty consultation is recommended for ongoing severe pain symptoms with no significant improvement in function despite treatment with opioids. Consultation should address possible undiagnosed conditions, psychological conditions affecting treatment, and alternative treatments. The type of consultation obtained should be determined by the patient's presenting signs and symptoms and history. Consultation may be with, but not limited to, a physician specializing in psychiatry, neurology, anesthesiology, pain, physical medicine and rehabilitation, orthopedics, addiction medicine, rheumatology, or oncology. The Opioid Assistance Committee is also a resource for consultation. You may consider psychiatric and/or psychological consultation for intervention if a psychological condition is affecting treatment. Evaluation at a pain clinic can be a good option for patients reluctant to accept a mental health referral. Patients with signs of alcohol or other substance abuse should be referred to an addiction specialist.

### **Opioid management:**

Examples of when to seek assistance include:

- Patients on > 120mg MED/day
- Questions about methadone treatment
- Tapering patients off opioids
- Aberrant behavior

Although pain may be relieved at oral morphine doses up to 120mg MED/day, pain relief is not necessarily associated with psychological or functional improvement<sup>37</sup>. Because sustained functional improvement is so critical to effective opioid therapy for chronic pain, the prescriber should ensure that the patient meets the following conditions before considering a dosage above 120mg MED/day:

- There are no significant psychological issues or evidence of drug-seeking behaviors, AND
- The patient has demonstrated improvement in function and pain level previously at a lower dose.

If these conditions are met, the prescriber may seek a pain management consultation or case review to support possible treatment with opioid doses above 120mg MED/day.

Consultation with a specialist does not necessitate transfer of the patient for care or ongoing opioid prescribing. However, the consultant should advise the prescribing provider on a pain management plan and may include: alternative treatments to reduce or discontinue use of opioids, explanation of the risks and benefits of a possible trial with opioids above 120mg/day MED, and the need for ongoing documentation of improvement in function and pain.

## **Access to specialists and mentors**

In addition to obtaining consultation from the Opiate Assistance Committee or local pain specialists, you may also find it helpful to contact one of the following organizations that offer credentialing or certification in pain medicine:

- American Board of Pain Medicine
- American Board of Anesthesiology with certification of added qualifications in pain management

- American Board of Physical Medicine and Rehabilitation
- American Board of Psychiatry and Neurology

## **Tapering or discontinuing opioids**

Not all patients benefit from opioids, and a prescriber frequently faces the challenge of reducing the opioid dose or discontinuing the opioid altogether. Some reasons to discontinue opioids and/or refer to addiction specialists:

- No improvement in function and pain or
- Opioid therapy produces significant adverse effects or
- Patient exhibits drug-seeking or diversion behaviors such as:
  - Selling prescription drugs
  - Forging prescriptions
  - Stealing or borrowing drugs
  - Frequently losing prescriptions
  - Aggressive demand for opioids
  - Injecting oral/topical opioids
  - Unsanctioned use of opioids
  - Unsanctioned dose escalation
  - Concurrent use of illicit drugs
  - Failing a drug screen
  - Getting opioids from multiple prescribers
  - Recurring emergency department visits for chronic pain management (see section on Emergency Department Guidelines in [Appendix H](#), *Additional Resources*).

From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks). Some patients require frequent (weekly or twice weekly) dispensing of a few day's supply so they can follow the taper plan.
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant. Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring often for significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued. Rapid reoccurrence of tolerance can occur for months to years after prior chronic use.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms. \*[Provider list](#)

An **Opioid Taper Plan Calculator** is available in [Appendix H](#), *Additional Resources*.

## **Behavioral issues during opioid tapering**

Opioid tapers can be done safely and do not pose significant health risks to the patient. Special care needs to be taken by the prescriber to preserve the therapeutic relationship at this time. Otherwise, taper can precipitate doctor-shopping, illicit drug use, or other behaviors that pose a risk to patient safety. Behavioral challenges frequently arise when a prescriber is tapering the opioid dose and a patient places great value on the opioid he/she is receiving. In this setting, some patients may feel overwhelmed or desperate and will try to convince the prescriber to abandon the opioid taper. Challenges may include:

- Focus on right to pain relief (“You don’t believe I have real pain”)
- Arguments about poor quality of care with threats to complain to administrators or licensing boards
- Attributing one’s deteriorating psychological state, including suicidal thoughts, to opioid withdrawal.

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary. See [AFTER you decide with the patient to prescribe chronic opioid therapy](#). Serious suicidal ideation (with plan or intent) should prompt urgent psychiatric consultation<sup>39</sup>.

## **Part III: Guidelines for optimizing treatment when opioid doses are greater than 120mg MED/day**

Part III of this dosing guideline will assist primary care providers in optimizing treatment:

- When assessing effectiveness of opioid therapy in patients who exceed 120mg MED/day;
- When reducing the total daily opioid dose; and
- When discontinuing opioid therapy.

## **Assessing effects of opioid doses greater than 120mg MED/day**

Ongoing opioid therapy requires ongoing assessment to optimize therapy. This is important in light of the evidence that not all patients receive pain relief from opioids and some develop hyperalgesia and other abnormal pain sensitivity with chronic high dose opioid therapy. If, after using the guidelines under [Assessing effects of chronic opioid therapy](#), the prescriber feels that current treatment is not benefiting the patient, a dose reduction or discontinuation is warranted. If current treatment is benefiting the patient as demonstrated by objective measures of function and pain, it may be appropriate to continue, while establishing a plan to monitor therapy as the patient’s condition changes over time. See [Principles for safely prescribing chronic opioid therapy](#).

## **How to discontinue opioids or reduce and reassess at lower doses**

Treatment with opioids, even at high doses, will not eliminate all chronic pain, and some patients may do better on lower doses of opioids<sup>13,34,40</sup>. A decrease by 10% of the original dose per week is usually well tolerated. An **Opioid Taper Plan Calculator** is available in [Appendix H](#). Behavioral issues or physical withdrawal symptoms can be a major obstacle to an otherwise beneficial dose reduction. See [Tapering or discontinuing opioids and Recognizing and managing behavioral issues during opioid tapering](#).

The prescriber should assess the patient’s status periodically during the tapering process. If the chosen assessment tool indicates improved patient status other than subjective pain complaints, or if there is improvement in opioid-related side effects, maintain the patient off opioids or at the new reduced dose and reassess at a later time.

Conversely, if there is evidence of functional and symptomatic deterioration following opioid taper, the prescriber may consider consulting with a pain management specialist to evaluate additional therapeutic options.

## **Referrals to pain centers**

A referral for counseling or other support during opioid taper or dose reduction is recommended if there are significant behavioral issues. In addition, a multidisciplinary pain program may be considered when appropriate to address the psychosocial and cognitive aspects of chronic pain together with patients' physical rehabilitation<sup>41</sup>. Early consultative support may prevent pain from becoming a chronic disabling condition. \*[Local providers](#)

## **Recognizing aberrant behaviors during opioid therapy**

Patients who exhibit aberrant behaviors may be at risk for opioid abuse. There is no universally accepted screening tool to predict aberrant behaviors with opioid therapy for chronic pain. It is important to identify aberrant behaviors as they can affect the medical management of your patients and help predict misuse of opioids see [Reasons to discontinue opioids or refer for addiction management](#)<sup>42</sup>.

Patients with a co-morbid psychiatric condition or addiction are at higher risk of opioid misuse despite their attempts to follow the treatment plan<sup>38,43,44</sup>. Prescribers should intensify monitoring and scrutiny and seek a consultation with an addiction specialist if there is past or active substance dependence or abuse.

## **Referrals for addiction management**

A patient who exhibits overt signs of alcohol or substance use disorder should be referred to an addiction specialist for appropriate treatment. Prognosis is poor for patients with a DSM diagnosis of opioid dependence or abuse and who do not receive treatment<sup>45,46</sup>.

## **Local Pain Specialists**

The following providers may be accessed for assistance with recommendation for correct treatment of chronic pain:

- Dr. Rebeca Monreal 503-967-6771
- Mid Valley Pain Clinic-Phone 503-371-1970

## **Local Mental Health and Chemical Dependency Services**

- Bridgeway Recovery Services-Phone 503-363-2021
- Catholic Community Services-Phone 503-390-2600
- Marion County Adult Behavioral Health- Phone 503-588-5351
- New Perspectives-Phone 503-316-6770
- Northwest Human Services- Phone 503-588-5816
- Options Counseling- Phone 503-390-5637
- Valley Mental Health- Phone 503-589-4046

## **Part IV: Guidelines for Emergency Department Opioid Prescribing**

1. One medical provider should provide all opioids to treat a patient's chronic pain.
2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.
3. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
4. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
5. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
6. EDs are encouraged to share the ED visit history of patients with other emergency physicians who are treating the patient.
7. Physicians should send patient pain agreements to local EDs and work to include a plan for pain treatment in the ED.
8. Prescriptions for controlled substances from the ED should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.
9. EDs are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.
10. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.
11. EDs should maintain a list of clinics that provide primary care for patients of all payer types.
12. EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opioid abuse problems.
13. The administration of Demerol® (Meperidine) in the ED is discouraged.
14. For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary opioid prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.
15. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.
16. ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.
17. A patient's past prescription history should be checked through the Oregon Prescription Drug Monitoring Program web site before prescribing opioid pain medication.

18. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.

## Appendices

**Appendix A: Opioid Dose Calculations**

**Appendix B: Screening Tools**

**Appendix C: Tools for Assessing Function and Pain**

**Appendix D: Urine Drug Testing for Monitoring Opioid Therapy**

**Appendix F: Patient Education Resources**

**Appendix G: Sample Doctor-Patient Agreements for Chronic Opioid Use**

**Appendix H: Additional Resources to Streamline Clinical Care**

## Appendix A: Opioid dose calculations

Opioid	Recommended dose threshold for <u>pain consult</u> (not equianalgesic)	Recommended starting dose for opioid-naïve patients	Considerations
Codeine	800mg per 24 hours	30mg q 4–6 hours	See individual product labeling for maximum dosing of combination products. Avoid concurrent use of any OTC products containing same ingredient. See acetaminophen warning, below.
Fentanyl Transdermal	50mcg/hour (q 72 hr)		Use only in opioid-tolerant patients who have been taking ≥ 60mg MED daily for a week or longer
Hydrocodone	120mg per 24 hours	5-10mg q 4–6 hours	See individual product labeling for maximum dosing of combination products. Avoid concurrent use of any OTC products containing same ingredient. See acetaminophen warning, below.
Hydromorphone	30mg per 24 hours	2mg q 4–6 hours	
Methadone	40mg per 24 hours	2.5-5mg BID – TID	Methadone is difficult to titrate due to its half-life variability. It may take a long time to reach a stable level in the body. Methadone dose should not be increased more frequently than every 7 days. Do not use as PRN or combine with other long-acting (LA) opioids.
Morphine	120mg per 24 hours	Immediate-release: 10mg q 4 hours Sustained-release: 15mg q 12 hours	Adjust dose for renal impairment.
Oxycodone		Immediate-release: 5mg q 4–6 hours 80mg per 24 hours Sustained Release: 10mg q 12 hours	See individual product labeling for maximum dosing of combination products. Avoid concurrent use of any OTC products containing same ingredient. See acetaminophen warning, below.
Oxymorphone		Immediate-release: 5–10mg q 4–6 hours Sustained Release: 40mg per 24 hours 10mg q 12 hours	<b>Use with extreme caution due to potential fatal interaction with alcohol or medications containing alcohol.</b>
			<b>Meperidine and propoxyphene products should not be prescribed for chronic non-cancer pain.</b>

## Appendix B: Screening Tools

Based on a review of the literature and the consensus of the advisory committee, the first three highlighted tools are recommended for their clinical utility in screening opioid therapy patients.

	Risk of Opioid Addiction	Current/Past Substance Abuse	Depression, Mental/ Behavioral Health	Opioid Therapy	Administration	Time to Complete	Length	Available for Public Use (Cost)
Opioid Risk Tool (ORT) See Page 19.	X				Clinician or patient self-report	5 minutes	5 (yes/no) questions	X (Free)
CAGE Adapted to Include Drugs (CAGE-AID) See Page 20.		X			Clinician	< 5 minutes	4 (yes/no) questions	X (Free)
Patient Health Questionnaire 9 (PHQ-9) See Page 21.	X	Patient self- report				< 5 minutes	10 items	X (Free)
Screener and Opioid Assessment for Patients with Pain (SOAPP-R) <a href="http://www.painedu.org/soapp.asp">www.painedu.org/soapp.asp</a>	X				Patient self-report	< 10 minutes	24 items	X (Free, with licensing agreement)
Alcohol Use Disorders Identification Test (AUDIT) See Page 24.		X			Clinician or patient self-report	< 5 minutes	10 items	X (Free)
Center for Epidemiologic Studies Depression Scale (CES-D) See Page 26.			X		Patient self-report	5 minutes	20 items	X (Free)
Global Appraisal of Individual Needs Short Screener (GAIN-SS) See Page 29.			X		Staff or patient self-report	5 minutes	15 (yes/no) questions	X (Free)
Current Opioid Misuse Measure (COMM) <a href="http://www.painedu.org/soapp.asp">www.painedu.org/soapp.asp</a>				X	Patient self-report	< 10 minutes	17 items	X (Free, with licensing agreement)

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

## OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder	[ ]	2	2
	Obsessive Compulsive Disorder			
	Bipolar Schizophrenia			
	Depression	[ ]	1	1
<b>TOTAL</b>		[ ]		
<b>Total Score Risk Category</b>	Low Risk 0 – 3	Moderate Risk 4 – 7	High Risk $\geq 8$	

# CAGE-AID Questionnaire

Patient Name \_\_\_\_\_

Date of Visit \_\_\_\_\_

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

<b>Questions:</b>	<b>YES</b>	<b>NO</b>
1. Have you ever felt that you ought to cut down on your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning <b>to steady your nerves or to get rid of a hangover?</b>	<input type="checkbox"/>	<input type="checkbox"/>

## Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

## Psychometric Properties

The CAGE-AID exhibited:	<b>Sensitivity</b>	<b>Specificity</b>
One or more <b>Yes</b> responses	0.79	0.77
Two or more <b>Yes</b> responses	0.70	0.85

(Brown 1995)

# PHQ-9 — Nine Symptom Checklist

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

a. Little interest or pleasure in doing things

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

b. Feeling down, depressed, or hopeless

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

c. Trouble falling asleep, staying asleep, or sleeping too much

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

d. Feeling tired or having little energy

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

e. Poor appetite or overeating

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

g. Trouble concentrating on things such as reading the newspaper or watching television

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

i. Thinking that you would be better off dead or that you want to hurt yourself in some way

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Not Difficult at All**      **Somewhat Difficult**      **Very Difficult**      **Extremely Difficult**

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# PHQ-9 — Scoring Tally Sheet

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

**2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All 0	Somewhat Difficult 1	Very Difficult 2	Extremely Difficult 3

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# How to Score PHQ-9

## Scoring Method For Diagnosis

### Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

### Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

## Scoring Method For Planning And Monitoring Treatment

### Question One

- To score the first question, tally each response by the number value of each response:
  - Not at all = 0
  - Several days = 1
  - More than half the days = 2
  - Nearly every day = 3
- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

Score	Action
≤4	The score suggests the patient may not need depression treatment.
> 5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

### Question Two

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

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# AUDIT questionnaire: screen for alcohol misuse<sup>1</sup>

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2–4 times a month
- 2–3 times a week
- 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

3. How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- Never

- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the past year
- Yes, during the past year

### Scoring the audit

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (eg monthly) scoring 2, the fourth (eg weekly) scoring 3, and the last response (eg. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

<sup>1</sup>Saunders JB, Aasland OG, Babor TF *et al.* Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption — II. *Addiction* 1993, **88**: 791–803.



## Center for Epidemiologic Studies Depression Scale (CES-D)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the **past week**: (circle **one** number on each line)

During the past week...	Rarely or the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of none of the time (5-7days)
1. I was bothered by things that usually don't bother me .....	0	1	2	3
2. I did not feel like eating; my appetite was poor .....	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family.....	0	1	2	3
4. I felt that I was just as good as other people.....	0	1	2	3
5. I had trouble keeping my mind on what I was doing .....	0	1	2	3
6. I felt depressed .....	0	1	2	3
7. I felt that everything I did was an effort .....	0	1	2	3
8. I felt hopeful about the future .....	0	1	2	3
9. I thought my life had been a failure .....	0	1	2	3
10. I felt fearful .....	0	1	2	3
11. My sleep was restless .....	0	1	2	3
12. I was happy .....	0	1	2	3
13. I talked less than usual .....	0	1	2	3
14. I felt lonely .....	0	1	2	3
15. People were unfriendly .....	0	1	2	3

<b>During the past week...</b>	<b>Rarely or none of the time</b> (less than 1 day)	<b>Some or a little of the time</b> (1-2 days)	<b>Occasionally or a moderate amount of time</b> (3-4 days)	<b>All of the time</b> (5-7days)
16. I enjoyed life.....	0	1	2	3
17. I had crying spells .....	0	1	2	3
18. I felt sad .....	0	1	2	3
19. I felt that people disliked me .....	0	1	2	3
20. I could not "get going" .....	0	1	2	3

## Scoring

<b>Item Weights</b>	<b>Rarely or none of the time</b> (less than 1 day)	<b>Some of a little of the time</b> (1-2 days)	<b>Occasionally or a moderate amount of the time</b> (3-4 days)	<b>All of the time</b> (5-7 days)
Items 4, 8, 12, & 16	3	2	1	0
All other items:	0	1	2	3

Score is the sum of the 20 item weights. If more than 4 items are missing, do not score the scale. A score of 16 or greater is considered depressed.

## Characteristics

Tested on 175 subjects.

<b>No. of items</b>	<b>Observed Range</b>	<b>Mean</b>	<b>Standard Deviation</b>	<b>Internal Consistency Reliability</b>	<b>Test-Retest Reliability</b>
20	1-53	16.2	10.9	.91	NA

## Source of Psychometric Data

Stanford Arthritis Self-Management Study, 1996. Unpublished.

## Comments

We are no longer using the CES-D in multiethnic studies because we have found that the norms for various ethnic groups differ. This scale is available in Spanish.

## References

Radloff LS, The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 1977, pp.385-401.

*This scale is free to use without permission*

**Stanford Patient Education Research Center**

1000 Welch Road, Suite 204  
Palo Alto CA 94304 (650) 723-  
7935 (650) 725-9422 Fax  
self-management@stanford.edu  
<http://patienteducation.stanford.edu>

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## Appendix C: Tools for Assessing Function and Pain

**In the last month**, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

**No**

**Pain as bad as could be**

**In the last month**, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

**No interference**

**Unable to carry on activities**

**Interpretation of the Two Item Graded Chronic Pain Scale** – This two item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items.

For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

Similar pain ratings have been widely used in the Brief Pain Inventory, the Multidimensional Pain Inventory, and the Pain Severity Scale of the SF-12.

There is extensive research on the reliability, validity and responsiveness to change of these pain severity ratings, which is summarized in the following reference:

Von Korff M. Chronic Pain Assessment in Epidemiologic and Health Services Research: Empirical Bases and New Directions. Handbook of Pain Assessment: Third Edition. Dennis C. Turk and Ronald Melzack, Editors. Guilford Press, New York., In press

## **Appendix D: Urine Drug Testing for Monitoring Opioid Therapy**

### **i. Monitoring opioid therapy with urine drug testing (UDT)**

**ii. UDT algorithm for monitoring opioid therapy**

**iii. UDT clinical vignettes**

**iv. Frequently Asked Questions (FAQs) about UDT**

## i. Using Urine Drug Testing (UDT) to Monitor Opioid Therapy for Chronic Non-cancer Pain<sup>47-49</sup>

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse and verify compliance with treatment. If a decision has been made to prescribe opioids for chronic non-cancer pain, the prescriber should get a baseline UDT and screen all patients for risk level to develop an appropriate monitoring plan as well as a basis for consultation or referral. Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. The Prescriber should repeat random UDT based on the patient’s risk category. There are several validated screening tools available to assess risk of aberrant behavior. The Opioid Risk Tool (ORT) provides a brief questionnaire that can easily be used in the primary care setting (see Appendix B).

Prior to drug testing, the prescriber should inform the patient of the reason for testing, frequency of testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify the drug screen for the individual circumstances and more accurately interpret the results.

Risk Category	UDT Frequency	Drugs or Drug Classes to Test	Consideration
Low Risk by ORT	Periodic (e.g. up to 1/year)	<ul style="list-style-type: none"> <li>• Drug you are prescribing if not listed</li> <li>• Amphetamines</li> <li>• Opiates</li> </ul>	<p>Typically, the initial (screening) drug test uses an immunoassay method to identify the presence of a drug (presumptive positive). Because of cross-reactivity and different sensitivity and specificity between immunoassays, <b>a second confirmatory test is required</b> unless result is expected or the patient has disclosed drug use. Confirmatory drug tests use gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) to verify a presumptive positive result.</p> <p><b>Contact the laboratory director, toxicologist or a certified Medical Review Officer (MRO) in your area for questions about drug testing or result.</b></p> <p>If a point-of-care (POC) device is used, contact technical support from the manufacturer for questions.</p>
Moderate Risk by ORT	Regular (e.g. up to 2/year)	<ul style="list-style-type: none"> <li>• Cocaine</li> <li>• Benzodiazepines</li> </ul>	
	Frequent (e.g. up to 3-4/year)	<ul style="list-style-type: none"> <li>• Alcohol</li> <li>• Barbiturates</li> <li>• Oxycodone</li> <li>• Methadone</li> <li>• Fentanyl</li> <li>• Marijuana</li> </ul>	
	At time of visit  (Address aberrant behaviors in person, not by telephone)	<p>Testing for all drug classes may not be necessary, depending on clinical situation.</p>	

### UDT Results

Interpreting UDT results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. The table on the next page may aid prescribers when interpreting UDT results. The following UDT results should be viewed as a “red flag”, requiring confirmation and intervention:

- Negative for opioid(s) you prescribed
- Positive for drug (benzodiazepines, opioids, etc) you did NOT prescribe or have knowledge of
- Positive for amphetamine or methamphetamine
- Positive for alcohol
- Positive for cocaine or metabolites

If a **confirmatory drug test** substantiates a “red flag” result AND is:

- **Positive for prescribed opioid(s)**, prescriber should consider a controlled taper and a referral to an addiction specialist or drug treatment program depending on the circumstances.
- **Negative for prescribed opioid(s)**, prescriber should stop prescribing opioid(s) and consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

Drugs or Drug Classes	Detection Time in Urine*	Test to Order	Expected Results	Consideration
<b>Opioids or “opiates” – Natural (from opium)</b>				
Codeine (Tylenol #2/3/4)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – codeine, possibly morphine & hydrocodone	Immunoassays for “opiates” are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.
Morphine (Avinza, Embeda, MS Contin, Kadian)	1-3 days		Opiates Immunoassay – positive GC/MS or LC/MS/MS – morphine, possibly hydromorphone	
<b>Opioids – Semisynthetic (derived from opium)</b>				
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – hydrocodone, possibly hydromorphone	“Opiates” immunoassays may also detect semisynthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS) is required to verify compliance with the prescribed semisynthetic opioid(s).
Hydromorphone (Dilaudid, Exalgo)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS –hydromorphone	
Oxycodone (Roxicet, OxyContin)	1-3 days	Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – oxycodone possibly oxymorphone	Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.
Oxymorphone (Opana)	1-3 days	Opiates or Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates or Oxycodone Immunoassay – positive GC/MS or LC/MS/MS – oxymorphone	
<b>Opioids – Synthetic (man-made)</b>				
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	GC/MS or LC/MS/MS – fentanyl & norfentanyl	<b>Current “opiates” immunoassays do not detect synthetic opioids.</b> Thus confirmatory testing (GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.
Meperidine (Demerol)	1-3 days	GC/MS or LC/MS/MS Meperidine	GC/MS or LC/MS/MS – normeperidine, possibly meperidine	
Methadone (Methadose)	3-7 days	Methadone Immunoassay + GC/MS or LC/MS/MS Methadone	Methadone Immunoassay – positive GC/MS or LC/MS/MS – methadone & EDDP	
Propoxyphene (Darvon, Darvocet)	1-3 days	Propoxyphene Immunoassay + GC/MS or LC/MS/MS Propoxyphene	Propoxyphene Immunoassay – positive GC/MS or LC/MS/MS – propoxyphene & norpropoxyphene	
<b>Others</b>				
Alcohol	Up to 8 hours	Alcohol	Alcohol – see Consideration	Additional testing for alcohol metabolites, ethyl glucuronide (EtG) or ethyl sulfate (EtS), can identify alcohol up to 80 hours after consumption.
Amphetamines	2-3 days	Amphetamines, Methamphetamines or MDMA Immunoassay + GC/MS or LC/MS/MS Amphetamines	Amphetamines, methamphetamines or MDMA Immunoassay – see Consideration GC/MS or LC/MS/MS – amphetamine, methamphetamine or MDMA	Amphetamines immunoassays are highly cross-reactive so results should be interpreted cautiously, and may require consultation with the lab. They may detect other sympathomimetic amines, such as ephedrine, pseudoephedrine or selegiline. Confirmatory testing can identify which amphetamine is present.
Barbiturates	1-3 days w/short-acting; up to 30 days w/long acting	Barbiturates Immunoassay	Barbiturates Immunoassay – see Consideration	The clearance half-life of intermediate-acting barbiturates averages 24 hours. It takes about 5 to 7 half-lives to clear 98% of a drug dose. Thus, the presence of an intermediated-acting barbiturate indicates exposure within 5-7 days.
Benzodiazepines	1-3 days w/short-acting; up to 30 days w/long-acting	Benzodiazepines Immunoassay	Benzodiazepines Immunoassay – see Consideration GC/MS or LC/MS/MS – alprazolam, diazepam, clonazepam, lorazepam, etc.	Immunoassays for benzodiazepines have a 28% overall false negative rate and vary in cross-reactivity. Certain benzodiazepines (clonazepam and alprazolam) have limited detectability by most available immunoassays. Confirmatory testing is needed when use is expected or suspected.
Cocaine or benzoylecgonine	2-4 days	Cocaine Metabolites Immunoassay	Cocaine Metabolites Immunoassay – see Consideration	Cocaine immunoassays do not cross-react with other topical anesthetics that end in “caine” (e.g. lidocaine) and are highly specific for cocaine use.

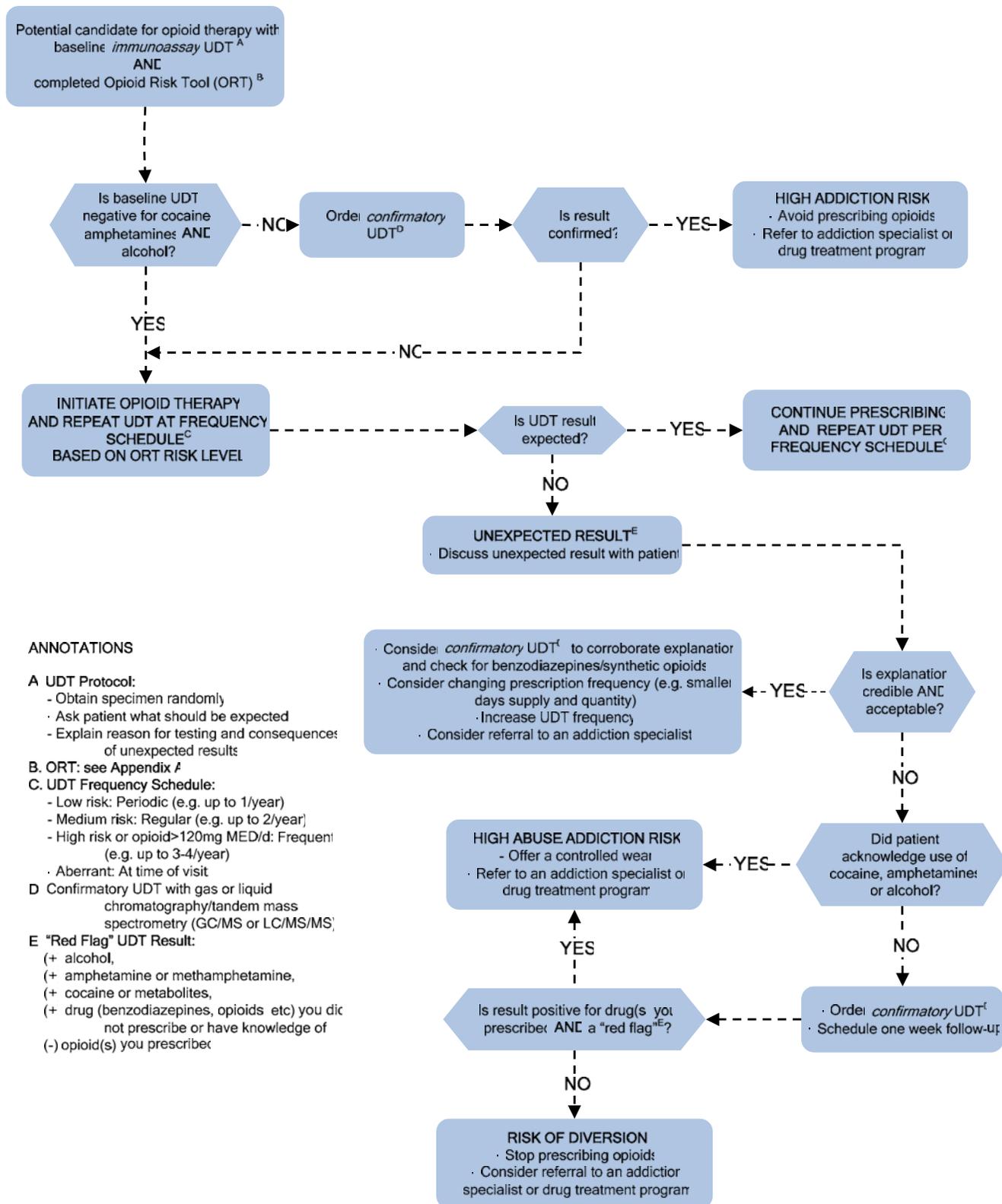
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Marijuana	2-4 days; up to 30 days w/chronic heavy use	Cannabinoids (THC) Immunoassay	Cannabinoids Immunoassay – see Consideration GC/MS or LC/MS/MS – THC	THC may be an indicator of the patient’s risk category. Prescribers should have an office policy, discuss with the patients reason for use and adjust monitoring plan accordingly.
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\*detection time for most drugs depends on the drug, dose, frequency of use and individual metabolism

## ii. Urine Drug Testing (UDT) Algorithm for Monitoring Opioid Treatment in Chronic Non-cancer Pain



### iii. UDT Clinical Vignettes in Chronic Non-cancer Pain

**New Patient:** A 31-year-old female with low back pain from an injury 2 months ago. She wants to establish care. According to the patient, she was initially prescribed naproxen and hydrocodone in the emergency room. She is currently taking naproxen OTC, but no reported opioids. Her other medical conditions include depression for which she takes citalopram. You are considering prescribing opioid(s) and your suspicion for drug abuse is low. What should you do?

**New Patient on Opioids:** A 45-year-old male presents with severe neck pain from a motor vehicle accident 2 years ago. He has been treated with OxyContin 30mg BID and oxycodone 5mg 1 tab Q3H PRN (MED = 150mg/day). He reports no history of substance abuse. Due to “personality differences” with previous provider, he would like you to assume care and continue prescribing OxyContin and oxycodone for his neck pain. You have no medical records to confirm previous treatment. What should you do?

**Compliance Testing in a patient on < 120mg MED/day:** A 55-year-old male with chronic knee pain comes in for a routine visit. His opioid regimen consists of methadone 5mg QID and hydrocodone/acetaminophen 5/500mg 1 tab Q6H PRN (MED = 100mg/day). He has moderate risk on ORT and last random UDT was a year ago. What should you do?

**Unexpected Results:** The immunoassays from the above vignette were positive for methadone, opiates and cocaine metabolites but negative for the remainder of the drug classes tested. Confirmatory testing with GC/MS was done per laboratory protocol. The confirmatory results show methadone, hydrocodone and benzoylecgonine (cocaine metabolite). What should you do?

IF you have decided to initiate chronic opioid therapy AND prior to prescribing, you should:

1. Obtain a baseline UDT (see drug or drug classes to test, page 1);
2. Assess risk of aberrant behavior with ORT;
3. Assess psychiatric status (e.g. PHQ-9);
4. Obtain a signed opioid agreement;
5. Establish treatment goals including improvements in both function and pain;
6. Describe expectations for behavior related to use of opioids (take as prescribed, use one pharmacy, one prescriber, no early refills, no self-escalation, no sharing of drugs, etc)
7. Develop a follow-up plan to monitor treatment, including the frequency of UDT's based on ORT

**Do not prescribe opioids at initial visit since records are unavailable:**

- Comprehensively evaluate the patient (see Guideline – *Before you decide to prescribe opioids for chronic pain*),
- Order a baseline UDT,
- **Inform patient that a signed release of information form is required prior to prescribing opioids.** Also request medical records from previous provider(s) or consider contacting the previous prescriber for information on treating this patient and
- Schedule a follow-up visit for when UDT results and medical records are available.

On follow-up visit, if UDT is consistent and prior medical records show improved pain and function with no history of aberrant behaviors, follow steps 2 – 7 above before prescribing.

Assess the risks and benefits of current opioid therapy (see Guideline – *Assessing effects of opioid therapy*). Discuss with the patient reason for testing, frequency of testing and consequences of unexpected results, order an immunoassay test for the drug classes below, and follow the UDT algorithm.

- Amphetamines
- Benzodiazepines
- Opiates
- Alcohol
- Cocaine metabolites
- Oxycodone
- Methadone

Discuss the unexpected results with the patient and offer a controlled taper and referral to an addiction specialist.

**Point of Care Testing:** A 47-year-old male with rotator cuff tendonitis has chronic shoulder pain managed with morphine SR 30mg TID and oxycodone/acetaminophen 5/325mg 1 tab Q4H PRN (MED = 135mg/day). He reports no other drug therapy. A treatment agreement has been signed by you and the patient recently. You perform a random UDT using a point-of-care testing kit. The immunoassays are positive for opiates but also positive for benzodiazepines. What should you do?

Discuss the unexpected results with the patient:

- If explanation is credible (e.g. receiving treatment for anxiety from another provider), you may want to send the urine sample to laboratory to confirm his story. You may also want to discuss future expectations with the patient and request records from other treating providers for possible specialty consultation.
  - If explanation is not accepted (e.g. patient admits benzodiazepine use that is not prescribed for the patient), confirmatory testing is not necessary but offer a controlled taper and/or referral to an addiction specialist depending on the circumstances.
  - If result cannot be explained, send original urine sample to laboratory for confirmatory testing.
-

## iv. UDT Frequently Asked Questions (FAQ)

### ○ Drug screening implies that I don't trust my patients. How do I get around this?

A Self-report of drug use has limited validity, and monitoring behavior alone can fail to detect problems revealed by UDTs. Creating a UDT policy in advance and applying it consistently to all patients on opioids may help de-stigmatize the testing. Inform patients that drug testing is a routine procedure for all patients starting or maintained on opioid therapy and it is an important tool for monitoring the safety of opioid therapy. Possible language for explaining to patient includes:

*f* “Ensures my capacity to provide treatment for your pain while balancing the need for safety.”

*f* “Provides critical information needed to assess the success of your therapy.”

*f* “Prescription medications are a common form of treatment for chronic pain. However, each person reacts differently to them. UDT enables us to identify individual risks related to your medications and avoid problems.”

*f* “Our clinic uses ‘universal precautions’ in opioid prescribing, which includes UDT. This is the same as wearing gloves on all patients when drawing blood.”

### ○ Can I tell whether my patient has taken the dose of opioid(s) I prescribed?

A No. It is very difficult to correlate urine drug concentration with a patient's dose. UDT can detect the parent drug and/or its metabolite(s) and demonstrate recent use of prescribed drugs and illegal substances. However, it CANNOT determine the amount of drug used and when the last dose was taken, nor can it identify the source of the drug.

### ○ My patient says he is a “high metabolizer” and that is why the expected drug is not found in the urine. Is this possible?

A A small percentage of persons are ultra rapid metabolizers. They metabolize specific drugs more rapidly than typical patients. It would be rare to take an opioid as prescribed and have a totally negative UDT. It is important that you use testing that is specific to the medication of interest and with cutoff thresholds that are extremely low.

### ○ How do I deal with marijuana?

A This is a complex issue. Marijuana is currently classified as a Schedule I drug by the DEA. For that reason, many providers will not prescribe opioids to patients using cannabis. Other providers reference State “Medical Marijuana” laws (<http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51A&full=true>) and feel comfortable prescribing opioids to cannabis users. Some providers adopt a “don't ask, don't tell” policy, and request the lab to remove marijuana from the UDT so that positive results are not seen. Do your homework and create an office policy. Then disclose this policy to your patients.

### ○ Would short-acting opioids show up in UDT?

A Urine testing typically has a 1 to 3-day window of detection for most drugs depending on dose and individual differences in drug metabolism. Short-acting opioids can be detected if the lab removes the cutoff concentration so that the presence of lower concentrations is detected. If the laboratory uses LC/MS/MS, then it will have a lower limit of detection (LOD) with less interference.

### ○ Why confirm results?

A Immunoassays used in drug screening can cross-react with other drugs and vary in sensitivity and specificity. Thus, confirmation with a more accurate method may be required for clinical decision making. Confirmatory drug testing (GC/MS or LC/MS/MS) of the original specimen is recommended for unexpected results, or in cases where patients are known to be high risk. However, on occasion, even confirmatory testing requires expert assistance for interpretation. Consider consultation with the lab before discussing/confronting the patient with unexpected test results and discontinuing opioid therapy.

○ **Should I use temperature and adulteration strips?**

A It depends. Drug testing for clinical compliance, unlike employment testing, does not require a strict “chain-of-custody”. However, if tampering is a concern, the specimen should be monitored for temperature and/or adulterants. Normal human urine should have a temperature between 90°F – 100°F, pH between 4.5 – 8.5 and creatinine >20mg/dL. Be aware that there are multiple websites and devices devoted to getting a “clean” urine drug screen.

○ **Should I perform a drug screen on every visit for patients using opioids for chronic pain?**

A No. Random screening based on the frequency recommended in the guideline should suffice for most patients. Those patients who you feel require drug screening on every visit, are perhaps not candidates for chronic opioid therapy.

|

## Appendix F: Patient Education Resources

Providing quality treatment for your patients is critical, and so is educating them about the risks of taking opioid medications. Resources that can help you provide this education are listed here.

Chronic Pain	
American Chronic Pain Association website <a href="http://www.theacpa.org">www.theacpa.org</a>	Education for individuals with chronic pain and their families. Includes communication tools, coping skills, ten steps to managing chronic pain, and online forums and videos.
American Pain Foundation <a href="http://www.painfoundation.org">www.painfoundation.org</a>	Information and resources about pain, online support, and information specifically for military personnel and veterans.
Pain Action <a href="http://www.painaction.com">www.painaction.com</a>	Self-assessment tools that provide individualized recommendations for evidence-based pain management, learning modules dedicated specifically to managing back pain and migraines, practical pain self-management techniques, managing the risks of opioid pain medications, and tips for pain management provided by peers.
Fibromyalgia Resources	
Fibromyalgia Information Foundation <a href="http://www.myalgia.com">www.myalgia.com</a>	Overview of fibromyalgia, diagnosis, treatment, preventive advice and new research discoveries.
Know Fibro <a href="http://www.knowfibro.com">www.knowfibro.com</a>	A self-management program for people living with fibromyalgia, and fibromyalgia basics.
Headaches	
National Headache Foundation <a href="http://www.headaches.org">www.headaches.org</a>	A headache education program centered on the key principles of headache care. Education for patients and providers.
Medication Resources	
<a href="http://www.medicinenet.com">www.medicinenet.com</a>	Provides easy to read, in depth medical information for patients.
Mental Health Issues	
Anxiety Disorders Association of America <a href="http://www.adaa.org">www.adaa.org</a>	General information about anxiety disorders, how to find help, and tips for managing anxiety.
Depression screening.org <a href="http://www.depressionscreening.org">www.depressionscreening.org</a>	Confidential online depression screening test, symptoms and treatments, personal stories and sources of help.
National Institute of Mental Health <a href="http://www.nimh.nih.gov/index.shtml">www.nimh.nih.gov/index.shtml</a>	General information about mental health topics including signs and symptoms, treatment, and locating local services.
Protecting your medications	
The Addiction Technology Transfer Center Network <a href="http://www.nattc.org/topics/RxAbuse/docs/safemed.pdf">www.nattc.org/topics/RxAbuse/docs/safemed.pdf</a>	Six tips for preventing others from stealing your prescription medicines.

General information about sleep health and safety, and sleep-related problems.

### **Sleep**

National Sleep Foundation  
[www.sleepfoundation.org](http://www.sleepfoundation.org)

### **Setting Patient Health Goals**

Structuring Your Own Management of Pain (STOMP) brochure, available at:  
[www.swedish.org/documents/08881\\_CME\\_Stomp%20Book\\_General.pdf](http://www.swedish.org/documents/08881_CME_Stomp%20Book_General.pdf)

Brochure is designed to help patient set health goals that will alleviate the patient's pain and improve the quality of their life. It includes general information about pain, goal-setting ideas and steps to take to achieve those goals.

Includes opioid safety, possible risks from taking opioids, and warning signs of drug abuse or addiction. Tips on preventing overdoses, signs of overdose and problematic opioid use.

### **Opioid Safety**

<http://takeasdirected.doh.wa.gov>

- Pain patient page
- Overdose Prevention Brochure

The use of a pain management agreement allows for the documentation of understanding between a doctor and patient. Agreements should be discussed and signed by both parties. They can also serve as an aid for patient education.

### **Sample pain treatment agreements**

[www.Lni.wa.gov/ClaimsIns/Files/OMD/LIOpioidTreatmentAgreement0708.pdf](http://www.Lni.wa.gov/ClaimsIns/Files/OMD/LIOpioidTreatmentAgreement0708.pdf)  
<http://hrsa.dshs.wa.gov/pharmacy/ChronicPainAgreement.pdf>

*Treat Your Own Neck and Back* by R. McKenzie

Patient handbook for common neck pain will help patients learn to relieve their problems and prevent recurrence of their symptoms in the future. It covers a step-by-step system of education, awareness, exercise and prevention.

*Managing Pain Before It Manages You* by M Caudill

Simple set of tools to help patients live with their pain more effectively and independently.

*Mind Over Mood: Change How You Feel by Changing the Way You Think* by D Greenberger and C Padesky

Step by step worksheets teach specific skills to conquer common mental health issues such as depression, anxiety, and low self-esteem.

*Thoughts and Feelings: Taking Control of Your Moods and Your Life* by M. McKay, M.Davis, and P.Fanning

Adapts the powerful techniques of cognitive behavioral therapy into a set of tools readers can use against anxiety, depression, and obsessiveness.

*The War on Pain* by S. Fishman & L. Berger

An introduction to interdisciplinary pain management that integrates traditional and alternative techniques.

*Heal Your Headache: The 1-2-3 Program for Taking Charge of Your Pain* by D. Buchholz & S.G. Reich

Information on how to avoid triggers, use of preventative medications rather than pain relievers which can cause rebound headaches.

*Chronic Pain Solution: Your Personal Path to Pain Relief* by J.N. Dillard & L.A. Hirschman

Useful information on how to approach and relieve chronic pain.

*Snoring and Sleep Apnea: Sleep Well, Feel Better* by R. Pascualaly

This book is for people with sleep apnea, family, friends and health care professionals. Covers causes, diagnosis, treatment, and surgical techniques.

# Appendix G: Sample Doctor-Patient Agreements for Chronic Opioid Use

## OPIOID TREATMENT AGREEMENT

**Patient Name:** \_\_\_\_\_

**Claim No.** \_\_\_\_\_

<p><b>Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day.</b>                  Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.                  I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.</p>			
<p><b>1. I understand that I have the following responsibilities:</b></p> <ul style="list-style-type: none"> <li>a. I will take medications only at the dose and frequency prescribed.</li> <li>b. I will not increase or change medications without the approval of this provider.</li> <li>c. I will actively participate in Return to Work (RTW) efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).</li> <li>d. I will not request opioids or any other pain medicine from providers other than from this one. This provider will approve or prescribe all other mind and mood altering drugs.</li> <li>e. I will inform this provider of all other medications that I am taking.</li> <li>f. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist.</li> <li>g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.</li> <li>h. I agree to participate in psychiatric or psychological assessments, if necessary.</li> <li>i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:                      12-step program and securing a sponsor                      Individual counseling                      Inpatient or outpatient treatment                      Other: _____</li> </ul>	<p><b>2. I understand that in the event of an emergency,</b> this provider should be contacted and the problem will be discussed with the emergency room or other treating provider. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other provider without this provider's approval.</p> <p><b>3. I understand that I will consent to random drug screening.</b> A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.</p> <p><b>4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.</b></p> <p><b>5. I understand that this provider may stop prescribing opioids or change the treatment plan if:</b></p> <ul style="list-style-type: none"> <li>a. I do not show any improvement in pain from opioids or my physical activity has not improved.</li> <li>b. My behavior is inconsistent with the responsibilities outlined in #1 above.</li> <li>c. I give, sell or misuse the opioid medications.</li> <li>d. I develop rapid tolerance or loss of improvement from the treatment.</li> <li>e. I obtain opioids from other than this provider.</li> <li>f. I refuse to cooperate when asked to get a drug screen.</li> <li>g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.</li> <li>h. If I am unable to keep follow-up appointments.</li> </ul>		
<b>Patient Signature</b>	<b>Date</b>	<b>Provider Signature</b>	<b>Date</b>

**PLEASE READ AND SIGN REVERSE SIDE**

<p><b>Provider:</b>                  Keep signed copy in file, give a copy to patient and send a copy to L&amp;I.                  Must renew Agreement every 6 months.</p>
---

**Patient Name:**

**Claim No.** \_\_\_\_\_

**Your safety risks while working under the influence of opioids**

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

**Side effects of opioids**

Confusion or other  
change in thinking  
abilities  
Nausea  
Constipation  
Vomiting

Problems with coordination or  
balance that may make it unsafe to  
operate dangerous equipment or  
motor vehicles  
Sleepiness or drowsiness

Breathing too slowly – overdose  
can stop your breathing and lead  
to death  
Aggravation of depression  
Dry mouth

**These side effects may be made worse if you mix opioids with other drugs, including alcohol.**

**Risks**

**Physical dependence.** This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

Runny nose

Abdominal cramping

Rapid heart rate

Diarrhea

Sweating

Nervousness

Difficulty sleeping for several days

Goose bumps

**Psychological dependence.** This means it is possible that stopping the drug will cause you to miss or crave it.

**Tolerance.** This means you may need more and more drug to get the same effect.

**Addiction.** A small percentage of patients may develop addiction problems based on genetic or other factors.

**Problems with pregnancy.** If you are pregnant or contemplating pregnancy, discuss with your provider.

**Payment of medications**

State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your provider should discuss other sources of payment for opioids when L&I can no longer pay.

**Recommendations to manage your medications**

Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.

Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.

Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

**Patient Signature**

**Date**

**Provider Signature**

**Date**

**PLEASE READ AND SIGN REVERSE SIDE**

**Provider: Keep signed copy in file, give a copy to patient and send a copy to L&I. Must renew Agreement every 6 months.**

## Model Pain Management Agreement

I, \_\_\_\_\_ (*patient receiving chronic **pain** medications*), agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that \_\_\_\_\_ (*name*) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

\_\_\_\_\_ I will only take medications at the amount and frequency prescribed.

\_\_\_\_\_ I will not increase or change how I take my medications without the approval of my pain management provider.

\_\_\_\_\_ I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours. I will make the necessary arrangements before holidays and weekends.

\_\_\_\_\_ I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_ I will allow my pain management provider to provide a copy of this agreement to my pharmacy.

\_\_\_\_\_ I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.

\_\_\_\_\_ I understand that other physicians should not change doses of my pain medications made by another provider.

\_\_\_\_\_ I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.

\_\_\_\_\_ I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.

\_\_\_\_\_ In event of an emergency, I will give this same information to emergency department providers.

\_\_\_\_\_ I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.

\_\_\_\_\_ I will inform my pain management provider of any new medications or medical conditions.

\_\_\_\_\_ I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.

\_\_\_\_\_ I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

\_\_\_\_\_ In addition, I will do the following (initial each box):

\_\_\_\_\_ I must take a drug test this often: \_\_\_\_\_

\_\_\_\_\_ I agree to pill counts to prove I am using my medications correctly

\_\_\_\_\_ If I fail a drug test, I will take the drug test more often at (frequency of) \_\_\_\_\_

\_\_\_\_\_ If I fail a drug test, I will be referred to Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (<http://maa.dshs.wa.gov/PRR>)

\_\_\_\_\_ If I sell my narcotics, my name will be referred to the DSHS fraud unit.

\_\_\_\_\_ If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and/or changes in my providers.

Provider: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider: \_\_\_\_\_ Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

## Appendix H: Additional Resources to Streamline Clinical Care

The following resources are available to help clinicians manage the care of chronic pain patients who are receiving opioids.

., **Department of Social and Health Services (DSHS) Tool Kit** to help address drug and alcohol issues in Medicaid patients  
<http://maa.dshs.wa.gov/pharmacy/ToolKit.htm>

., An **Opioid Taper Plan Calculator** is available and makes it easier for prescribers to calculate safe and effective taper plans for patients who would benefit from lower opioid doses. It was developed by Washington State Medicaid in collaboration with the University of Washington pain management experts.  
(<http://hrsa.dshs.wa.gov/pharmacy/pdf/TaperSchedule.xlsx>).

., **DSHS Division of Alcohol and Substance Abuse** at 877-301-4557. A referral for treatment may be made to any one of the licensed opioid therapy programs (OTPs) in Washington State:  
<http://www1.dshs.wa.gov/DASA/services/certification/GB.shtml> and click on Appendix Q.

., **Physician Clinical Support System** has mentors available to help you, by phone or email, with questions on methadone or buprenorphine. In addition, guidance on specific clinical questions and helpful tools can be downloaded from the website. There is no cost for this service. Once you register at <http://www.pcssmentor.org/> a mentor will be assigned to you within 2 days.

., List of providers for pain management consultation  
[www.agencymeddirectors.wa.gov/guidelines.asp](http://www.agencymeddirectors.wa.gov/guidelines.asp)

., **Collaborative Opioid Prescribing Education (COPE)**, an online training to improve doctor-patient communications and collaborative goal-setting. COPE training is available through the University of Washington CME website:  
<http://depts.washington.edu/cme/online/course/EN0705>

., **CDEMS** is the Chronic Disease Electronic Management System, a **free** Microsoft Access database application designed to assist medical practices in tracking the care of patients with chronic health conditions. Originally designed to track diabetes, asthma and adult preventive health, it has also been adapted to monitor other chronic conditions such as pain. It can produce printed progress notes, patient lists, and summary reports which can help measure quality improvement efforts. CDEMS files and User's Guide are downloadable for free at <http://cdems.com/>

., **My Pain Profile** is a web based program that uses multiple tools to provide clinicians with information in an easy to use format about patients' pain, mood, quality of life, and function. Over time, it screens, monitors, and reports clinical progress on risk of opioid misuse, abuse and diversion, and the efficacy of pain treatments. This is available through the Chronic Pain Impact Network (CPAIN [www.CPAIN.com](http://www.CPAIN.com); contact [wa.info@CPAIN.com](mailto:wa.info@CPAIN.com)). Data from the CPAIN registry can help define which treatments work best in which patients and who should be referred for specialty care. Please note that CPAIN is a commercial product for which a charge is made to the insurer (not the clinician or patient) and as such cannot be endorsed by AMDG.

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