OPIOID PRESCRIBING IN OKLAHOMA FOR CHRONIC NON-CANCER PAIN

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- Board Certified in Anesthesiology
- Board Certified Subspecialty Pain Management

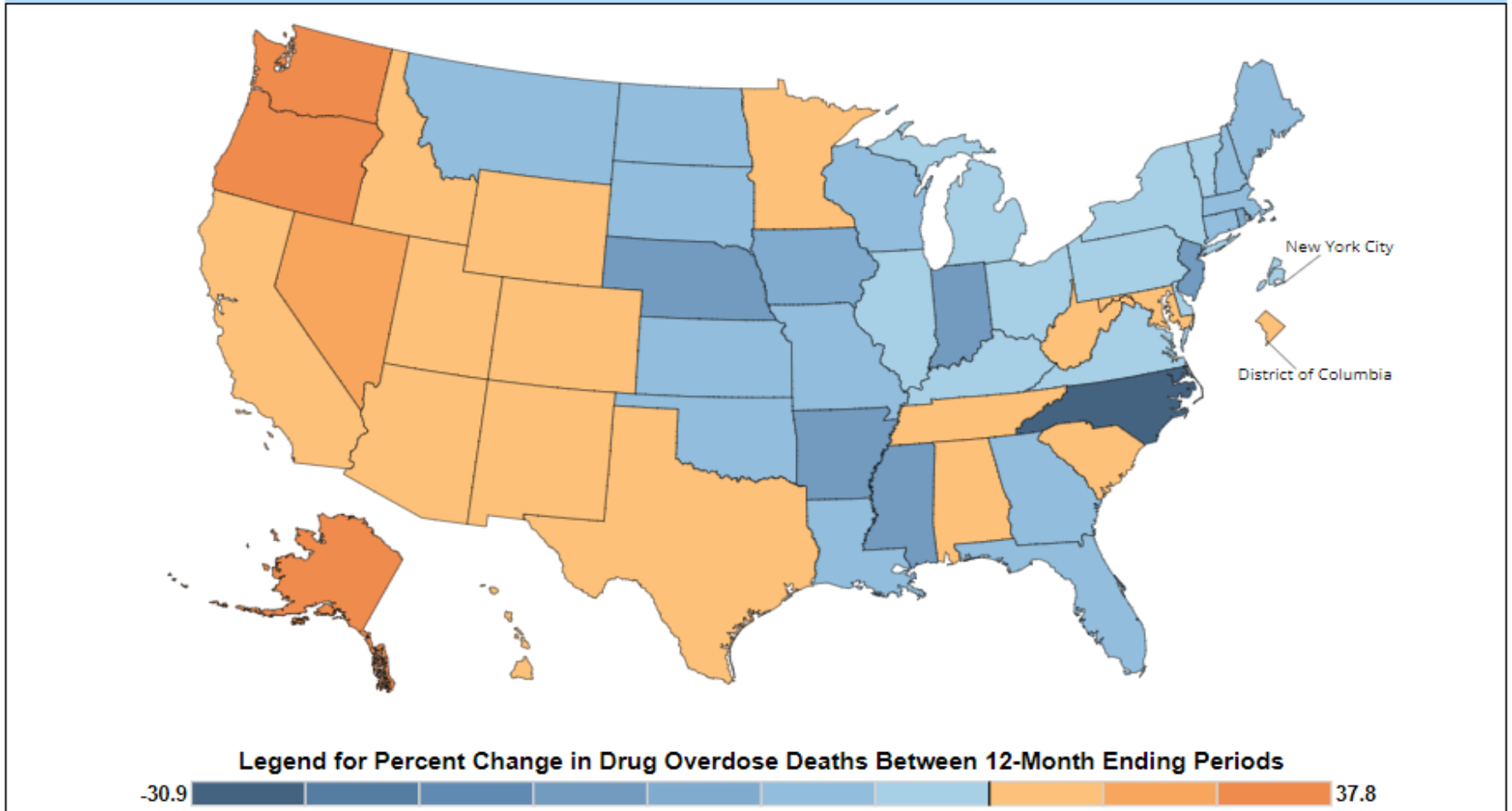
CONFLICTS OF INTEREST

NONE

AFTER PARTICIPATING IN THIS PRESENTATION, THE PHYSICIAN SHOULD BE ABLE TO:

- Understand history of opioid prescribing
- Diagnosis opioid use disorder patient's
- Understand 2022 CDC Recommendations
- Correctly prescribed opioids in Oklahoma

Figure 1b. Percent Change in Reported 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: October 2022 to October 2023



Select predicted or reported number of deaths

- ○ Predicted
- ◉ Reported

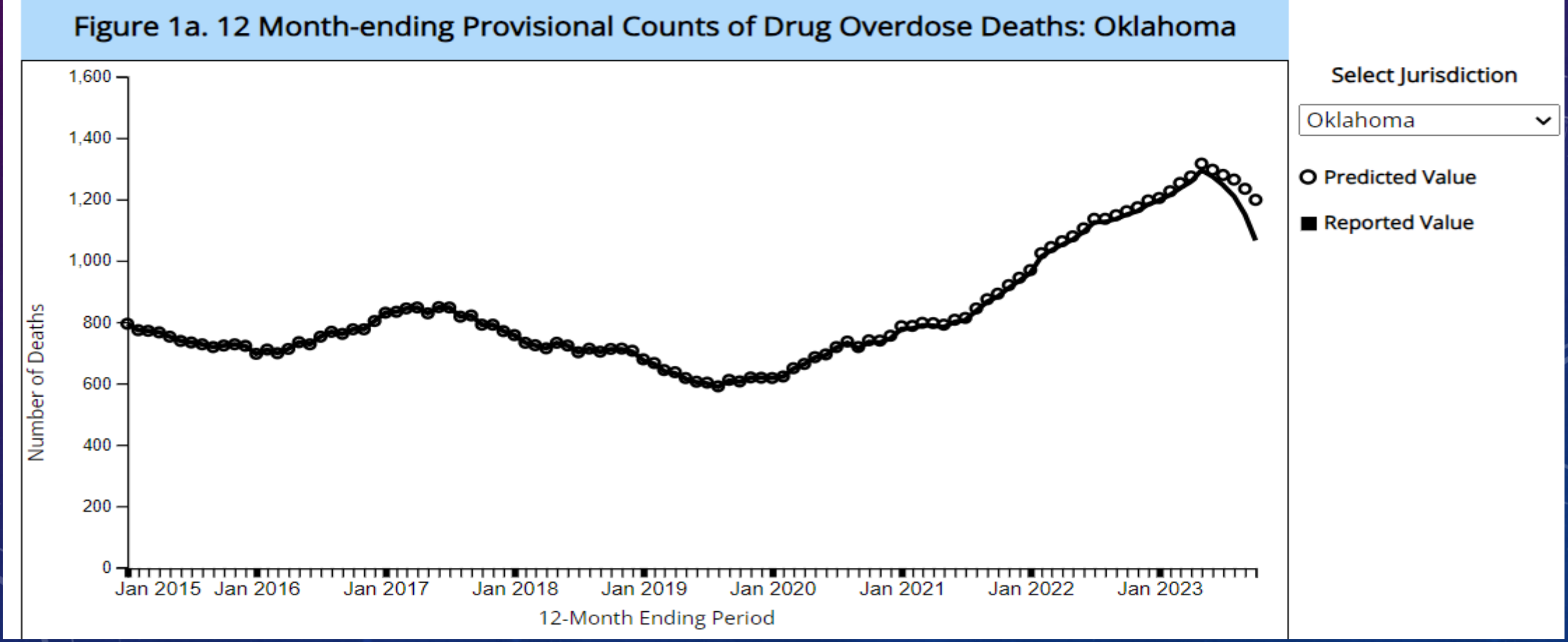
Percent Change for United States

-2.3

OKLAHOMA DECREASED BY 2.3%

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

OKLAHOMA OVERDOSE DEATHS

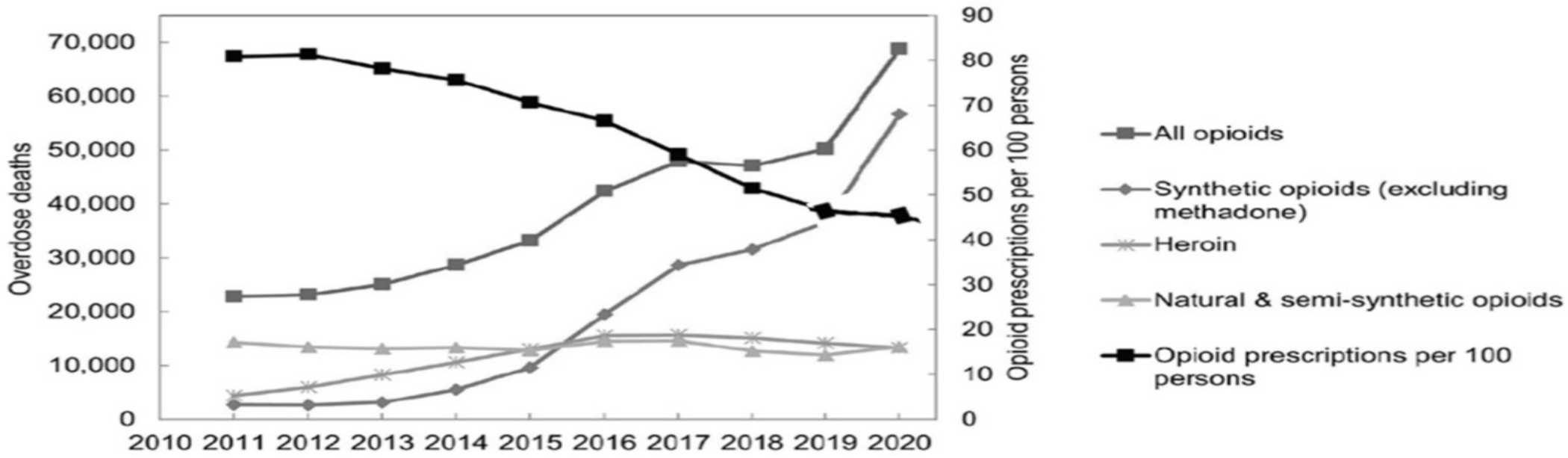


Reductions in opioid prescribing have not led to reductions in drug-related mortality

Source: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

US opioid overdose deaths & opioid prescribing

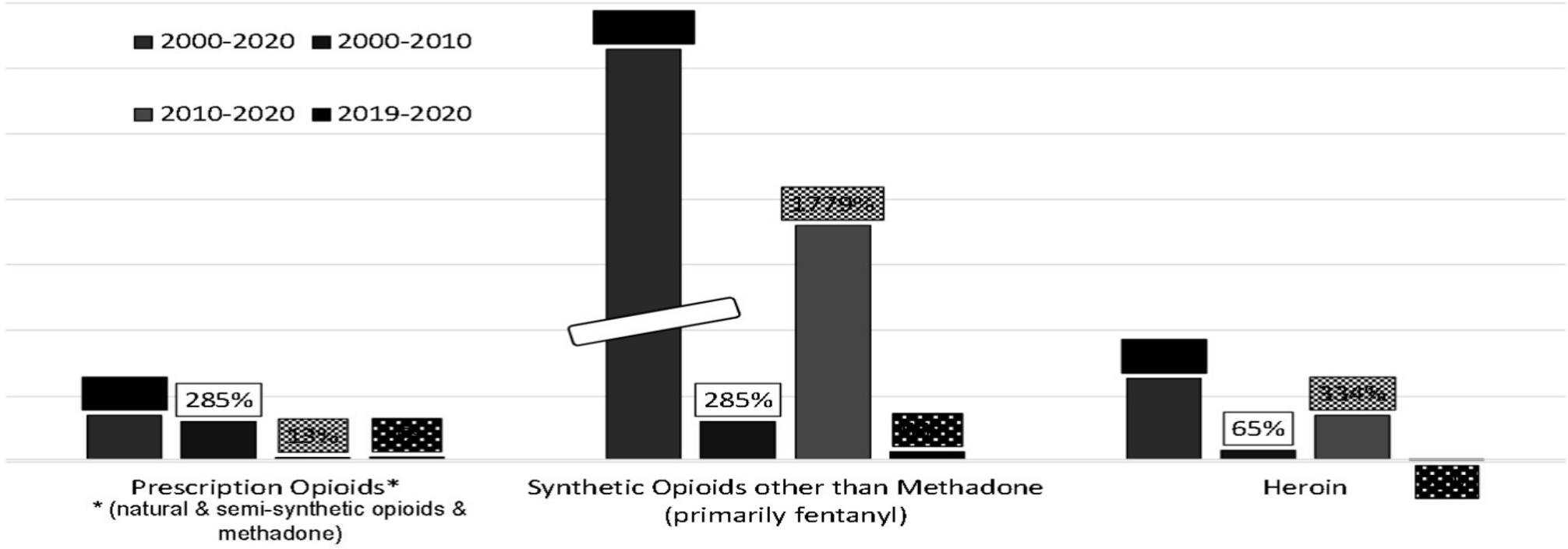
The opioid paradox



The opioid paradox. Opioid prescriptions are declining while opioid overdose deaths are increasing

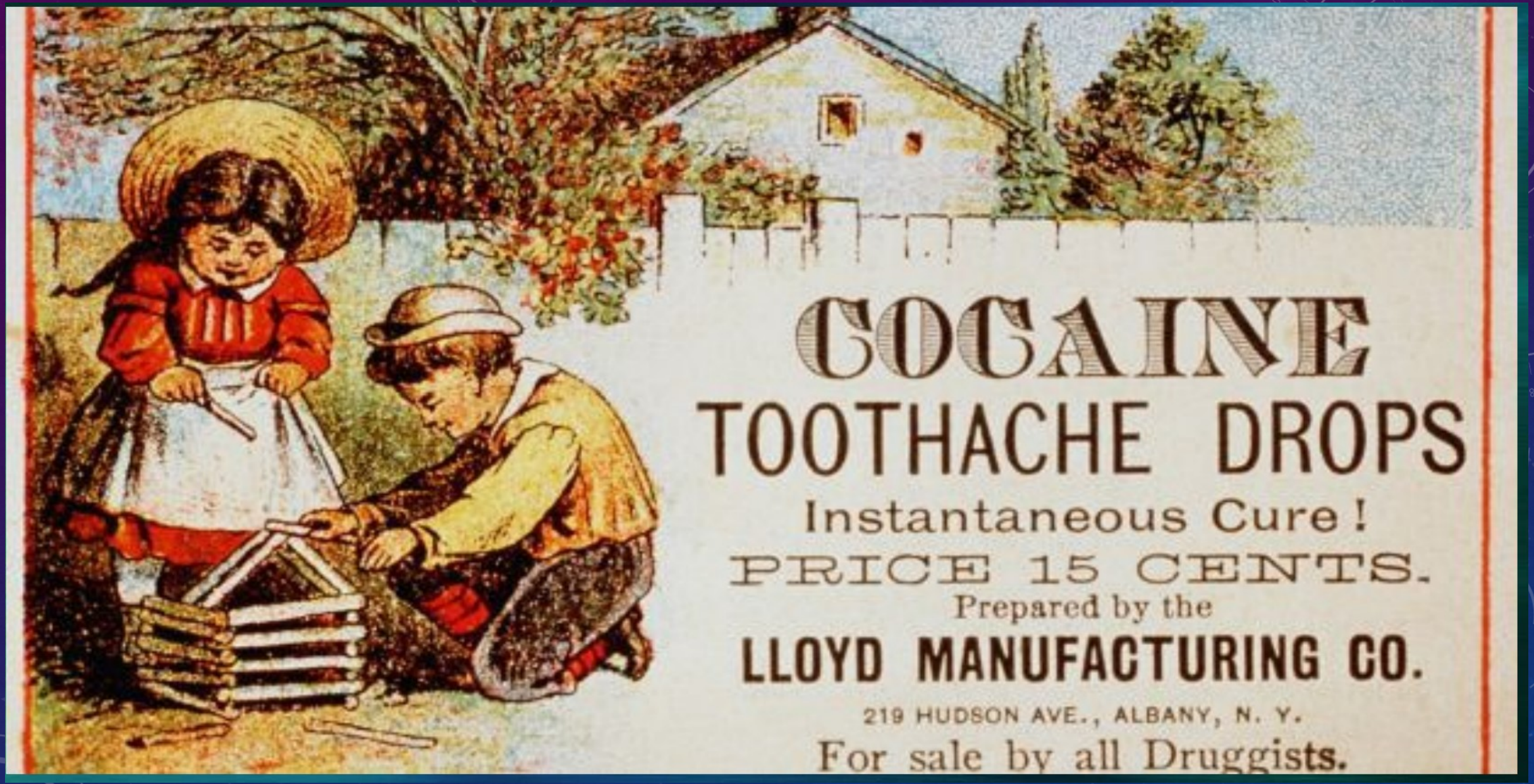
Source: Opioids and Public Health: The Prescription Opioid Ecosystem and Need for Improved Management
Kharasch et al. ANESTHESIOLOGY 2022; 136:10–30

Quantification of Opioid Deaths 2000-2020



	2000	2010	2017	2018	2019	2020	Change 2000-2020	Change 2000-2010	Change 2010-2020	Change 2019-2020
Prescription Opioids (natural & semi-synthetic opioids & methadone)	3,785	14,583	17,029	14,975	14,139	16,416	334%	285%	13%	16%
Synthetic Opioids other than Methadone (primarily fentanyl)	782	3,007	28,466	31,335	36,359	56,516	7127%	285%	1779%	55%
Heroin	1,842	3,036	15,482	14,996	14,019	13,165	615%	65%	334%	-6%

Source: deShazo R et al. Backstories on the U.S. Opioid Epidemic Good Intentions Gone Bad, an Industry Gone Rogue and Watch
Dogs Gone to Sleep. Am J Med. 2018 Feb 1.

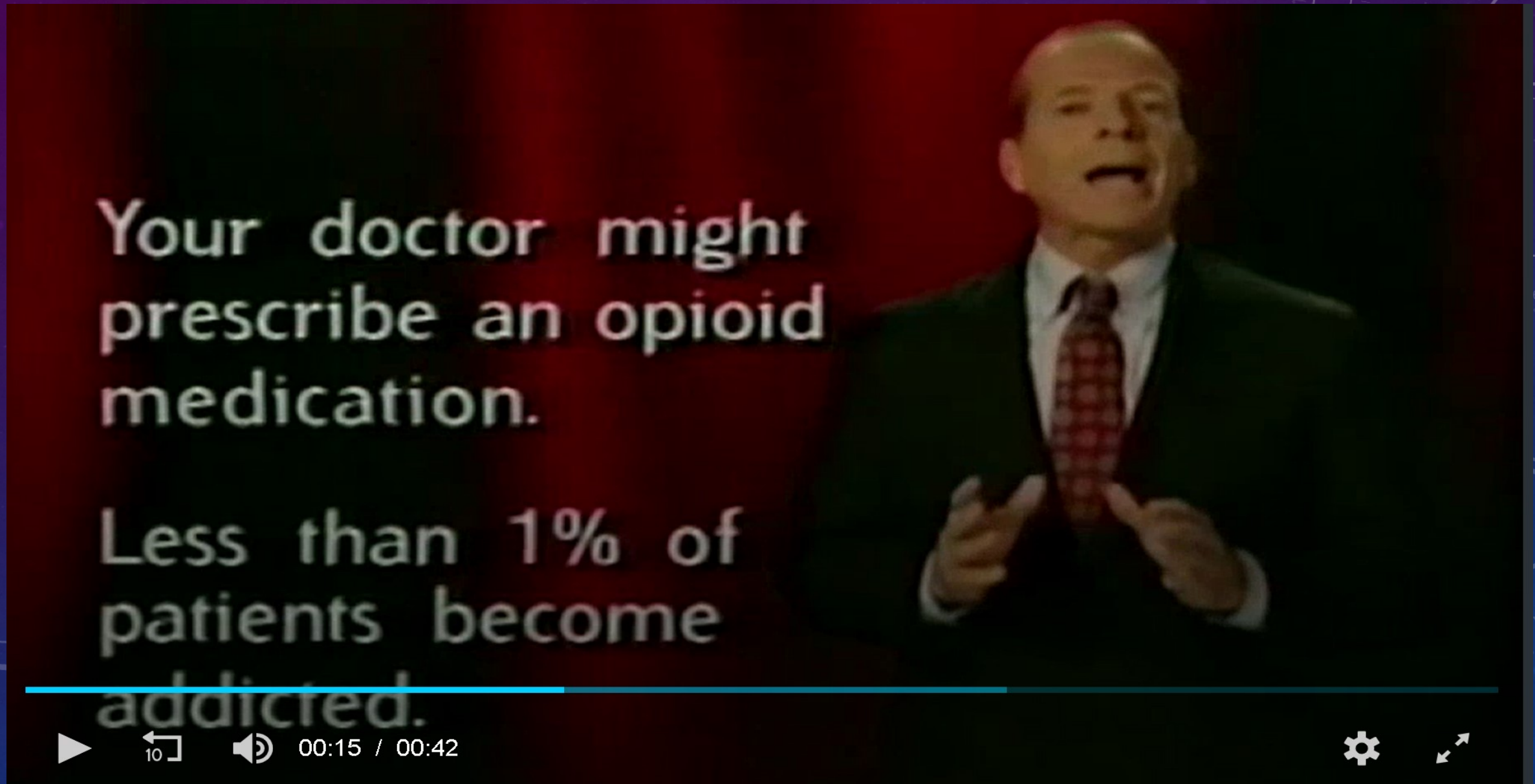

COCAINE
TOOTHACHE DROPS
Instantaneous Cure!
PRICE 15 CENTS.
Prepared by the
LLOYD MANUFACTURING CO.
219 HUDSON AVE., ALBANY, N. Y.
For sale by all Druggists.

1885

TIME LINE

Date	Title	action
1995	American Pain Society quality care committee creates	PAIN AS 5TH VITAL SIGN
1995	Oxycontin approved	
1998	Federation of state medical boards	Policy telling doctors would not face regulatory action for prescribing opioids even in high dose
2000	Joint Commission on Accreditation on Health care JCAHO	Encourages a 10 point scale for pain
2002	INCREASE IN OPIODS	IN 5 YEARS OXYCODONE INCREASED BY 402% Morphine increased by 73% Hydromorphone by 96%

OXYCONTIN COMMERCIAL 1998



OXYCONTIN

- 1995 FDA approved OxyContin
- Dr. Curtis Wright team medical review officer for the FDA advocated for OxyContin approval
- 2 years later Dr. Wright began working for OxyContin
- “showing very low risk of addiction”
- FDA required removal of these above claims by OxyContin 2001

Date	Title	action
2004	Federation of state medical boards	Recommends sanctioning doctors who under treat pain
2007	Purdue (oxycontin) sued for 634 million	Misleading advertisement misrepresenting addictive of oxycontin
2009	JACAHO	Removed requirement to access all patient for pain
2011	CDC	Declares epidemic on overdose on opioids

Date	Title	action
2014		Opioid overdose death increased to 200% from 2000
2016	AMA	Drops pain as 5th vital sign
2016	CDC opioid Guidelines	
2016	Comprehensive addiction and recovery active 2006	Authorizes 181 million for prevention and treatment of opioid epidemic
2019	SB 1446 AND 848	Established Oklahoma Law NOT GUIDELINES
2022	CDC Updated opioid GUIDLINES	

RECOMMENDED LESS THAN 90 MEQ OF MORPHINE

MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

- Very low – Inadequate
  - Hydrocodone 5 mg QD
  - Hydrocodone 5 mg BID
  - Hydrocodone 5 mg TID
- Low to Moderate
  - 30-40 MME – Low
  - 40-90 MME – Moderate
- High
  - > 90 MME
- CDC
  - 50 MME –
  - > 90 MME - HIGH

WWW.CDC.GOV/MMWR/CME/CONTED.HTML

2022 CDC GUIDELINES

1: DETERMINING WHETHER TO INITIATE OPIOIDS FOR PAIN

2: SELECTING OPIOIDS AND DETERMINING DOSAGES

3: DECIDING DURATION OF ADDITIONAL OPIOID PRESCRIPTION AND CONDUCTING FOLLOW-UP

4: ASSESSING RISK AND ADDRESSING POTENTIAL HARM OF OPIOID USE

DETERMINING WHETHER OR NOT TO INITIATE OPIOIDS FOR PAIN

- **Recommendation #1: (acute pain<1month):**
  - **Nonopioid therapy at least as effective as opioid therapy**

- **Recommendation #2: (Subacute1-3 months and chronic pain>3 months)**
  - Nonopioid therapies are preferred for subacute and chronic pain

OPIOID-INDUCED ADVERSE EFFECTS

Category	Adverse effect
Common	Constipation Dizziness Fatigue Impaired cognition Nausea vomiting Pruritus Sexual dysfunction Sedation Testosterone deficiency
Severe	Opioid-induced respiratory depression Addiction/dependent Death
Other risk	Falls Hyperalgesia

NONOPIOID THERAPY

- : Physical therapy
- : Massage therapy
- : TENS units
- : NSAIDs (if patient is a candidate)
- : Tricyclic antidepressants
- Anticonvulsants (pregabalin/gabapentin)
- lidocaine patches for neuropathic pain/allodynia
-

- Heat
- Ice
- Duloxetine
- Muscle relaxants
- Cognitive behavioral therapy
- Yoga tai chi
- Acupuncture
- Interventional pain procedures

PRIOR TO PRESCRIBING

Determine specific treatment goals

- Functional goals
  - Make pain manageable versus eliminating pain
- Have exit strategy
  - If the opioids do not work or become out-of-control should be established
- Discussion on securing opioids from pets and Children

SELECTING OPIOIDS AND DETERMINE OPIOID DOSAGES

- Recommendation #3
  - Should prescribe immediate release instead of long-acting
  - Greater than 50 milliequivalents of morphine usually has greater harm than benefit
- Recommendation #4
  - Opioid naïve patients should be prescribed lowest effective dose
- Recommendation #5
  - For patients already on opioids risk and benefits should be weighed
  - Should taper no less than 10 %/week
  - Patient centered discussions

#5 SHOULD CONSIDER TAPERING OPIOIDS IF

- 1. Patient request to decrease
- 2. Pain improves, or medical condition resolved
- 3. Patient has been on opioids and experiences an overdose or hospitalization/adverse event secondary to opioid use
- 4. Patient starts receiving benzodiazepines or has increased medical conditions that would affect opioids sleep apnea, liver disease, kidney disease
- 5. Patient's pain and/or function has not improved to outweigh the risk/side effects

METHADONE

- Germany 1939 (Germany) WWII
- No titration should occur before 7 days
- Half-life 15-60 hours roughly 50 hours
- Analgesic effect is only 6-12 hours
- Metabolites buildup in the body
- Significant respiratory depression
- NMDA receptor Blocker very helpful with neuropathic pain
- QT interval

3: DECIDING DURATION OF ADDITIONAL OPIOID PRESCRIPTION AND CONDUCTING FOLLOW-UP

- Recommendation #6 : (Acute pain)
  - Prescribe no greater than quantity needed for expected duration of pain
- Recommendation #7 : (Subacute /chronic pain/dose escalation)
  - Should evaluate risk and benefits within 1 to 4 weeks
  - Greater than 50 mg of morphine milliequivalents should be followed up in 1 week
  - Methadone should be followed up in 2 to 3 days

4: ASSESSING RISK AND ADDRESSING POTENTIAL HARM OF OPIOID USE

- **Recommendation #8: Naloxone**
  - Should offer naloxone with history of substance abuse , sleep disorder , benzodiazepine use , greater than 50 milliequivalents of morphine
- **Recommendation #9: PMP**
  - State prescription monitoring program should be reviewed on initial prescription and at least periodically
- **Recommendation #10: TOXICOLOGY**
  - Toxicology should be considered before prescribing and at least periodically
  - Confirmatory should be utilized for unexpected screening toxicology and to confirm drug class

FREE NALOXONE STATE OF OKLAHOMA MAILED DIRECTLY NO COST

Please select your harm reduction supplies:

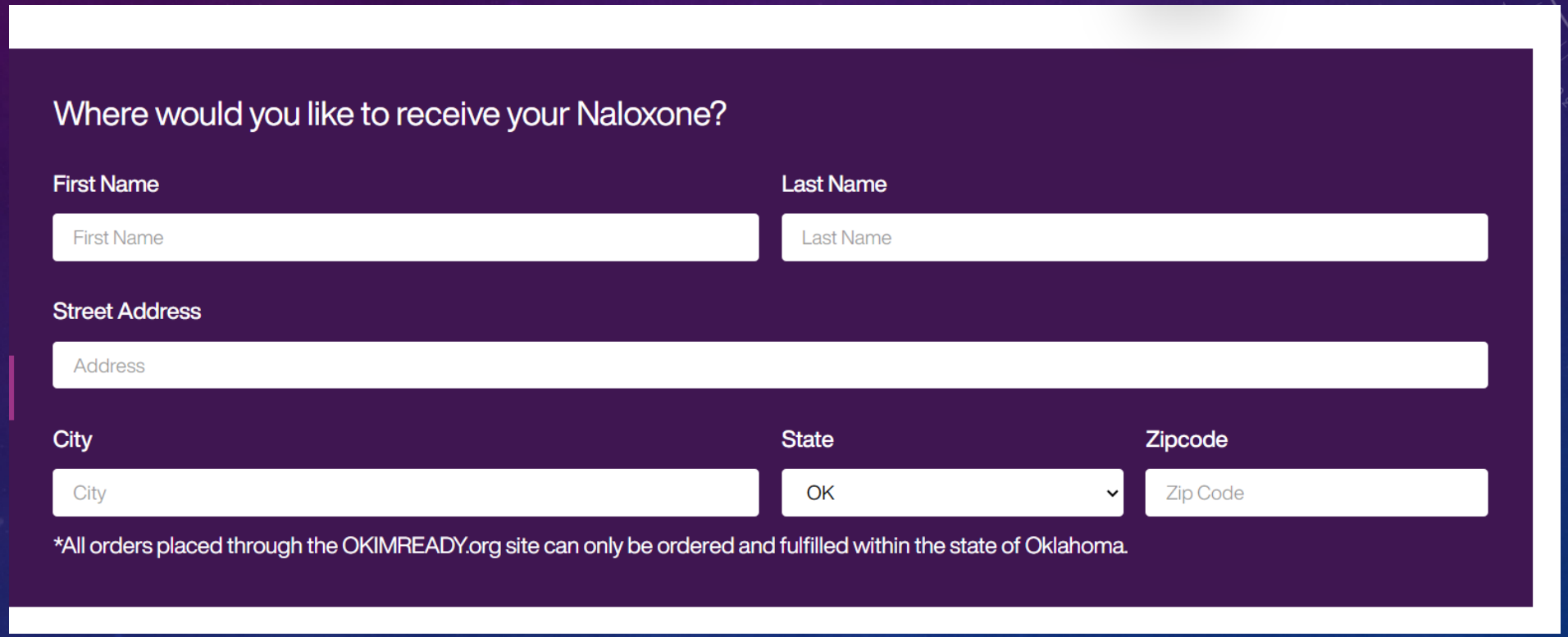
Naloxone

Fentanyl Test Strips

Both

https://okimready.org/overdose/

HTTPS://OKIMREADY.ORG/OVERDOSE/



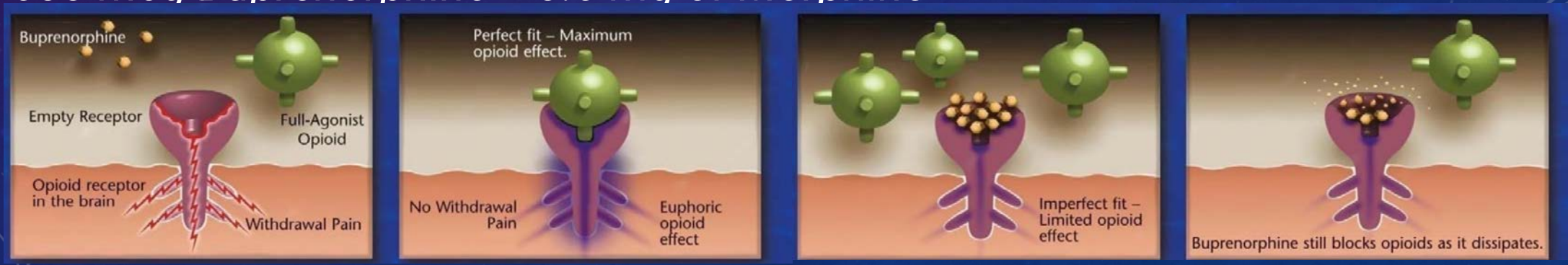
ASSESSING RISK AND ADDRESSING POTENTIAL HARM OF OPIOID USE CONT.

- **Recommendation #11: Benzodiazepines**
  - Use caution when prescribing opioids and benzodiazepines together
  - Up to 4 times increased risk of opioid death
  - Can be prescribed together would require increased monitoring and risk discussion

- **Recommendation #12: Opioid Use Disorder**
  - Opioid use disorder should offer and arrange treatment detoxification to include buprenorphine or methadone

BUPRENORPHINE

- Suboxone contains both buprenorphine and naloxone
- *Buprenorphine is a Schedule III*
- *600 mcg Buprenorphine = 0.6 mg of Morphine*



OPIOID EQUIVALENCE OF MORPHINE 60MG

	Equianalgesic dose MG
Hydromorphone	15
Oxycodone	40
Hydrocodone	60
Codeine	400
Methadone	20
Fentanyl	25 MCG PATCH

“TOLERANCE,” “DEPENDENCE,” AND “ADDICTION”?

- **Opioid tolerance**
- **Opioid dependence**
- **Opioid addiction** (Opioid use disorder (OUD)

OPIOID USE DISORDER DSM-V CRITERIA 2 OF 11 WITHIN THE LAST YEAR

- 1: Opioids are often taken in larger amounts or over a longer period than was intended
- 2: There is persistent desire or unsuccessful attempt to cut down or control opioid use
- 3: A great deal of time is spent in activities necessary to obtain the opioids, use the opioids or recover from its effect
- 4: Craving, or strong desire or urge to use opioids
- 5: Recurrent opioid use resulting in failure to fulfill major role obligations at work school or home

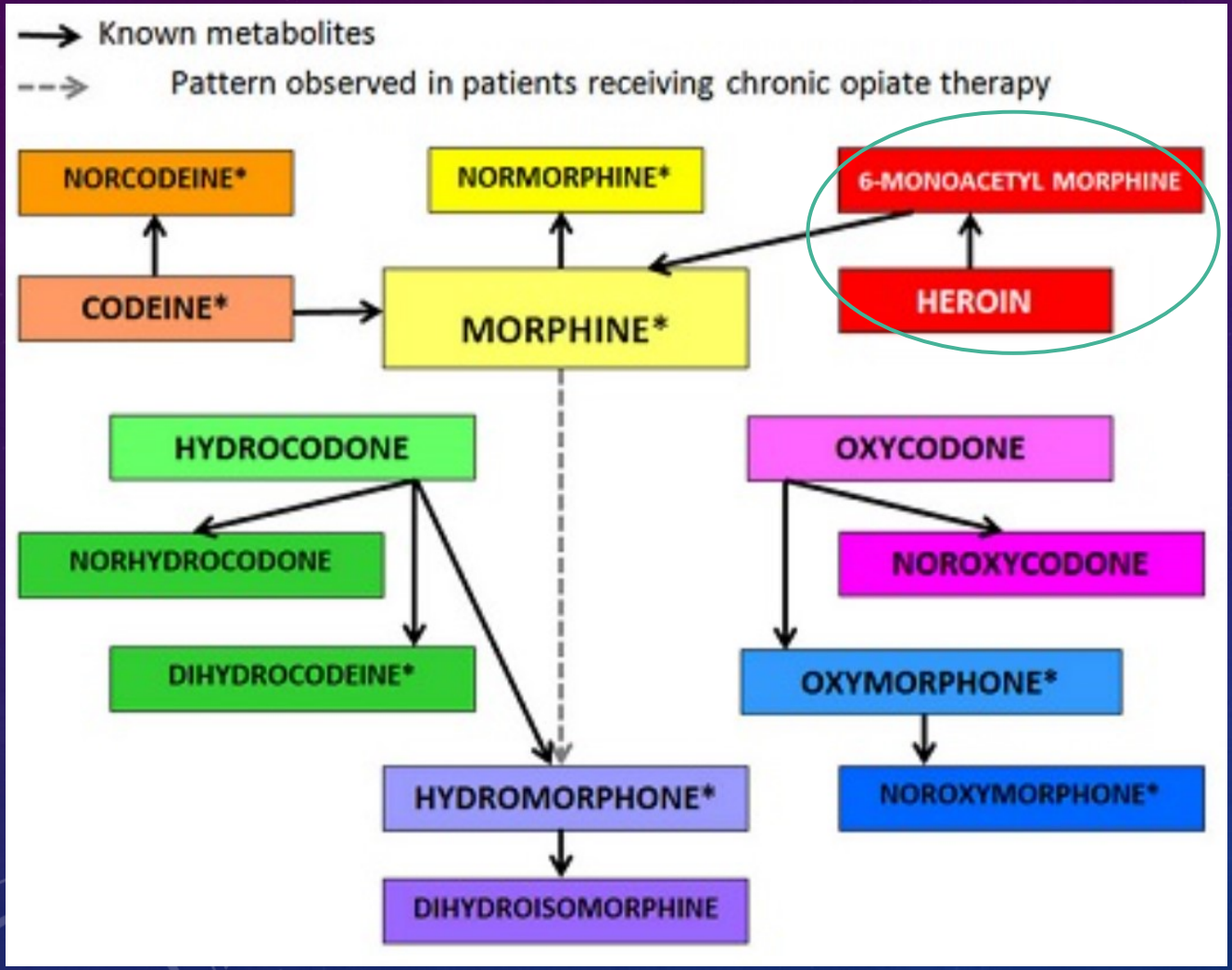
OPIOID USE DISORDER DSM-V CRITERIA 2 OF 11

- 6: **Continued opioid use** despite having persistent or recurrent social or intrapersonal problems caused or exacerbated by the effects of opioids
- 7: Important social, occupational, or recreational activities are given up or reduced because of opioid use
- 8: **Recurrent opioid use** in situations in which it is physically hazardous

OPIOID USE DISORDER DSM-V CRITERIA 2 OF 11

- 9: **Continued opioid use** despite knowledge of having persistent or recurrent physical or psychological problems is likely to have been caused or exacerbated by the substance
- 10: **Tolerance** as defined by either of the following
- A: Need for markedly increased amounts of opioids to achieve intoxication or desired effect or
- B: Markedly diminished effect with continued use of the same amount of opioid
- 11: **Withdrawal** as manifested by either of the following
  - A: Characteristic opioid withdrawal syndrome
  - B: opioids (or closely related sepsis) are taken to relieve or avoid withdrawal symptoms

URINE METABOLISM FOR OPIOIDS



hydromorphone positive
morphine
hydrocodone
codeine
heroin

morphine+
codeine
heroin
morphine

oxycodone
oxymorphone

URINE DRUG SCREENS

Urine Drug Screen length of time drugs stay in urine

Drug/Substance	Time
Alcohol	7-12 h
Amphetamine	48 h
Methamphetamine	48 h
Barbiturate	
Short-acting (eg, pentobarbital)	24 h
Long-acting (eg, phenobarbitol)	3 wk
Benzodiazepine	
Short-acting (eg, lorazepam)	3d
Long-acting (eg, diazepam)	30 d
Cocaine metabolites	2-4 d

Drug/Substance	Time
Marijuana	
Single use	3d
Moderate use (4 times/wk)	5-7 d
Daily use	10-15 d
Long-term heavy smoker	30 d
Opioid	
Codeine	48 h
Heroin (detected as morphine)	48 h
Hydromorphone	2-4 d
Methadone	3d
Morphine	48-72 h
Oxycodone	2-4 d
Propoxyphene	6-48 h
Phencyclidine	8d

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

alcohol	7 to 12 hours
amphetamine/ methamphetamines	48 hours
Valium	30 days
lorazepam	3 days
marijuana	30 days
morphine oxycodone hydromorphone codeine	2 to 4 days

OKLAHOMA
MANDATORY DOCUMENTATION BEFORE PRESCRIBING

• Disease process requiring opioids document i.e.. Diagnostic imaging, labs, physical
• Failed conservative care i.e. ,therapy, NSAIDS, ETC • 1st time prescribing Face to face required
• Follow up rx-Face to face recommended but not required
• Alternative treatments available
• Document the risk including respiratory depression as well as this discussion in the medical record
• Check the PMP prior to initial prescription

OKLAHOMA PRESCRIPTIONS

Acute pain since cannot exceed 7 days must state acute pain	**This includes patients on chronic opioids by another provider**
Second 7-day prescription must state acute pain	**Can be given if it shows documentation on rationale for prescription does not present an undue risk of abuse addiction or dose diversion**
Third prescription must state Chronic pain	**This prescription can be for 30 days**

OKLAHOMA CHRONIC PRESCRIPTIONS I.E., GREATER THAN 3 MONTHS

- Review treatment plan : minimum at least every 3 months
- Assess the patient prior to renewal:
  - verify not experiencing dependency or addictive behavior
- Periodically make efforts
  - To stop or decrease dose
  - Offer other treatment options
- Review PMP every 180 days at minimum
- Monitor compliance with provider agreement

OKLAHOMA SENATE BILLS 1446 AND 848

does not apply for
Active treatment for cancer
Hospice patient
Palliative care
Long-term care facility
Medications for treatment of substance abuse or opioid dependence

PATIENT PROVIDER AGREEMENT MUST BE INITIATED

1. At third prescription
2. Greater than 100 milliequivalents of morphine per day
3. Anytime prescription involves benzodiazepines with opioids
4. If patient is pregnant
5. With parent or legal guardian if minor is patient

Must have a written policy in the office for execution of written patient provider agreement

DEVELOP A TREATMENT PLAN

- Goal of at least 30% pain reduction
- Realistic that opioids are not going to take away all the pain
- Complete relief expectations is unrealistic
- Goal is to increase **functional status**
- Improved **quality of life**
- Improved **pain relief**
- **Treatment plan is important to review in follow up that opioids are showing benefit**

OPIOID PRESCRIBING IN OKLAHOMA

- 1. Check the PMP
- 2. Acute pain
  - First prescription cannot exceed 7 days face to face required
- 3. Chronic pain
  - Review course of treatment every 3 months
  - Evaluate for addiction and dependency
  - Periodically reevaluate and document efforts to decrease dose
  - Review PMP
  - Follow up prescription Face-to-face assessment is recommended but not required

THANK YOU!!