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:

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

Case presentation

- 37-year-old female new patient
- c/o all over body pain
- Referred for “fibromyalgia”
- MED HX: HTN, Depression, obese
- SH: smokes 1 pack per day, married, on disability

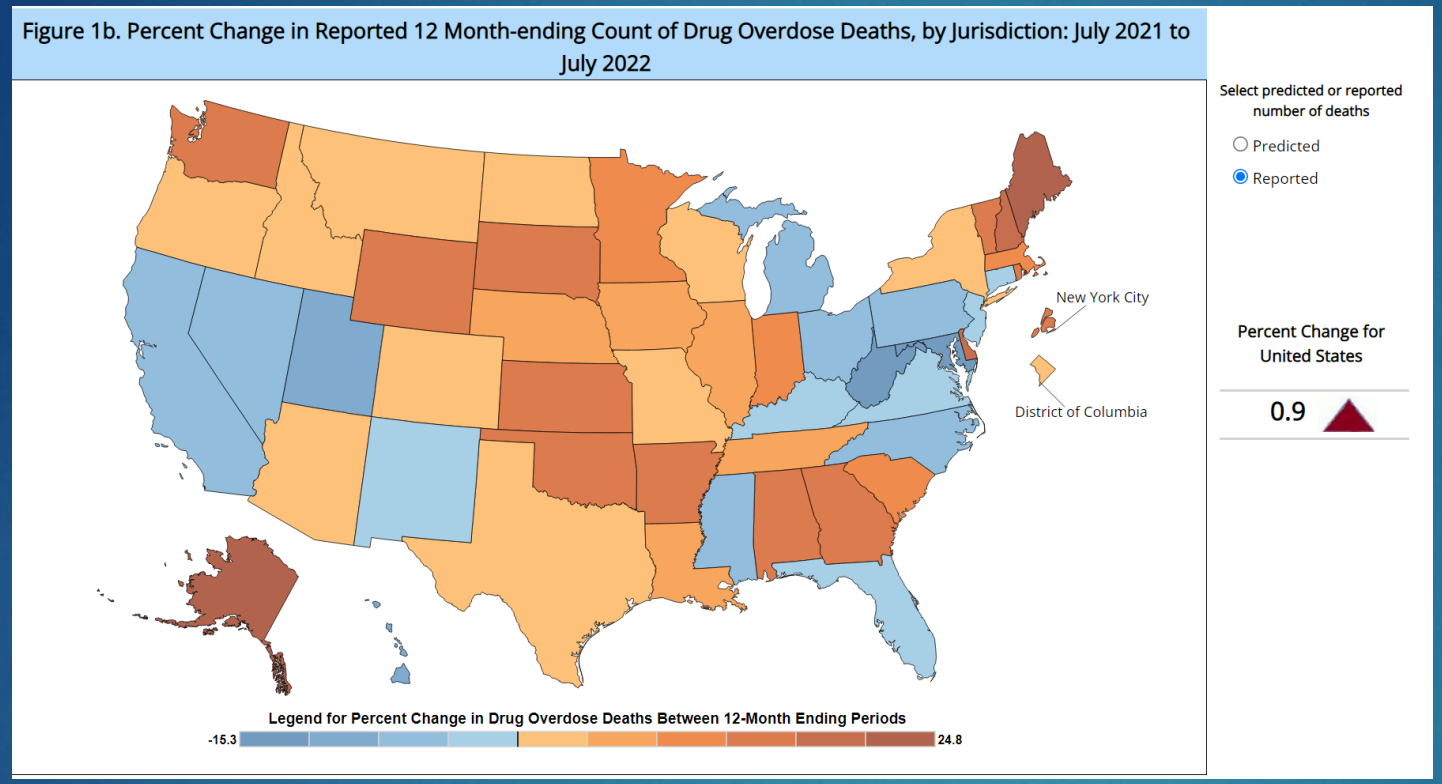
Case cont.

- Has been seeing pain management in Oklahoma city
- “Tired” of driving to Oklahoma city would like me to prescribe the same as her other doctor
- Pain on average 9/10 :Currently 8/10
- Taking 20 mg of OxyContin 3 times a day
- Taking 20 mg of Oxycodone for breakthrough pain 3 times a day
- No notes from previous provider

Concerns

- High dose narcotics
- At risk for respiratory depression
- No previous records to review
- Young age
- Nonspecific diagnosis
- Fibromyalgia has not been shown to respond to opioids
- Are there specific guidelines in Oklahoma to follow?
- What is the maximum recommended dose of opioids?

Increased Deaths Related to Covid?



Telehealth

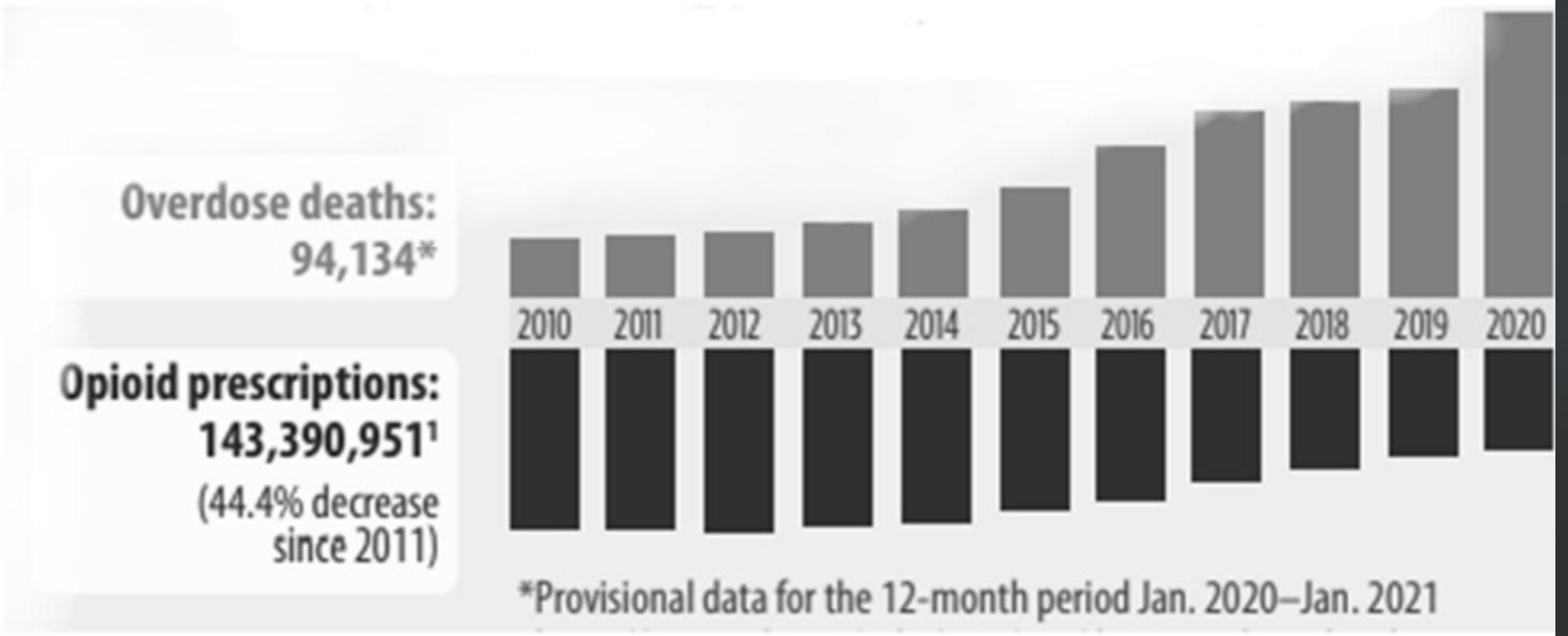
Extended visits

No UDS

Oklahoma Increased by 15.38%(930 from 806)

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

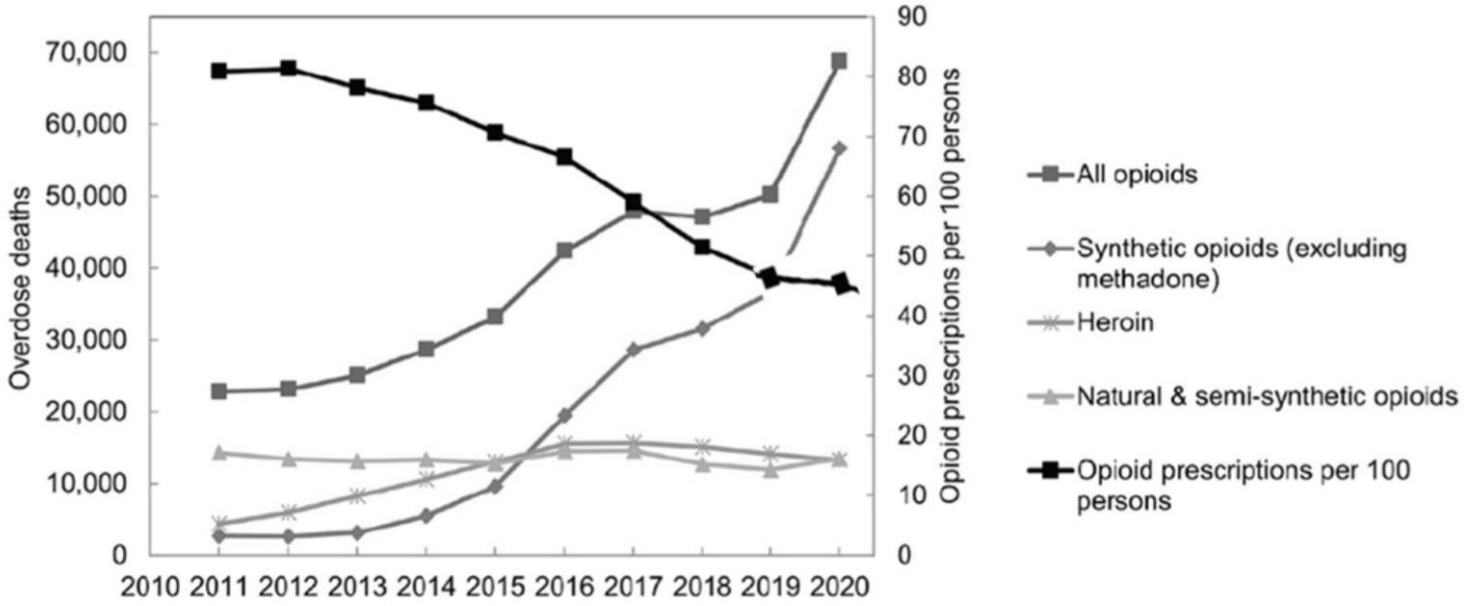
Reductions in opioid prescribing have not led to reductions in drug-related mortality



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

US opioid overdose deaths & opioid prescribing

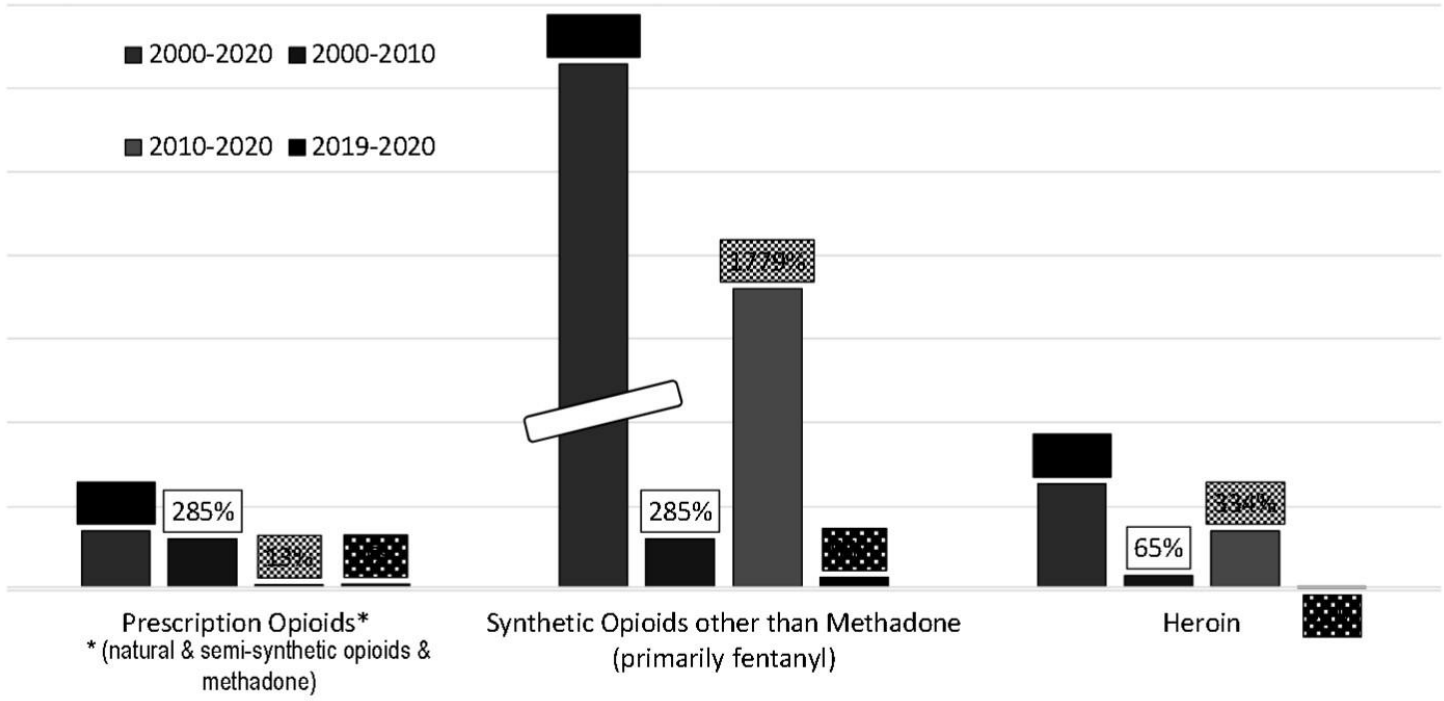
The opioid paradox



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

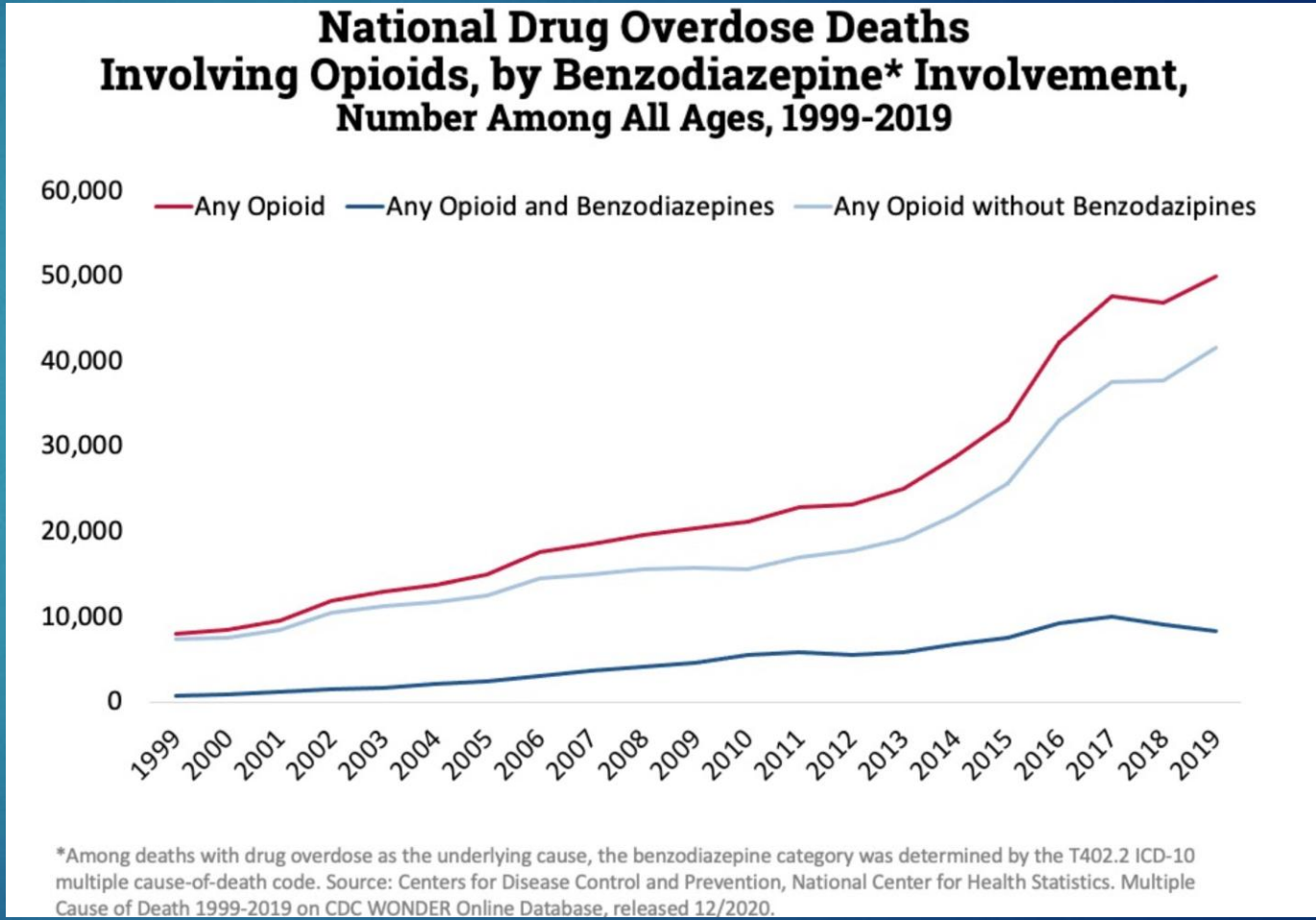
Quantification of Opioid Deaths 2000-2020



	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%

Opioids and Benzodiazepines

- 16% of opioid OD deaths in 2019
- Black box warning




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

Federal Legislation

date	title	action
1906	Pure Food and Drug Act	Requires opioids to be labeled as dangerous and addictive
1909	Smoking Opium Exclusion Act	Criminalizes importation possession or smoking opium
1924	Heroin Act	Makes possession and production of Heroin illegal
1919-1933	21st Amendment to the Constitution	Prohibition comprehensive drug Abuse Prevention Act

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.

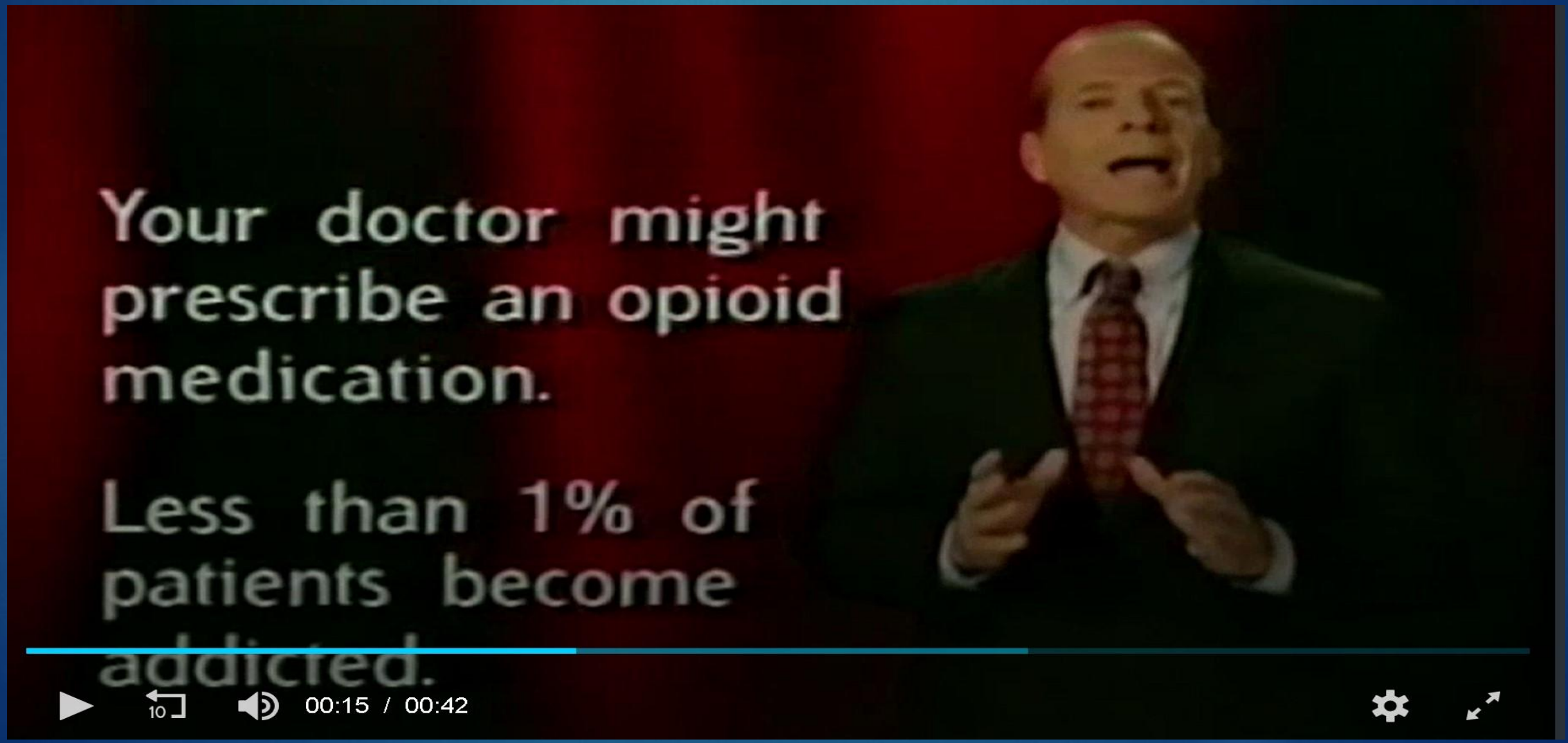
Federal Legislation

date	title	Action
1970	Controlled Substance Act	Regulates manufacture and distribution of narcotics 5 narcotics schedules marijuana (as schedule 1) becomes a controlled substance
1973	Reorganization	Establishes the DEA in the department of Justice

Federal Legislation

Date	Title	action
1974	Narcotic Addict Treatment Act	Allows physicians to register to provide narcotics to addicts for maintenance of treatment National Institute of Drug Addiction established (NIDA)
2016	Comprehensive addiction and recovery active 2006	Authorizes 181 million for prevention and treatment of opioid epidemic

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

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

Oklahoma Senate Bills 1446 AND 848

- Effective as of May 21, 2019

SB 1446 AND SB 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

2022 CDC Guidelines/ Recommendations

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

2: 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

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

4: Assessing risk and addressing potential harm of opioid use cont.

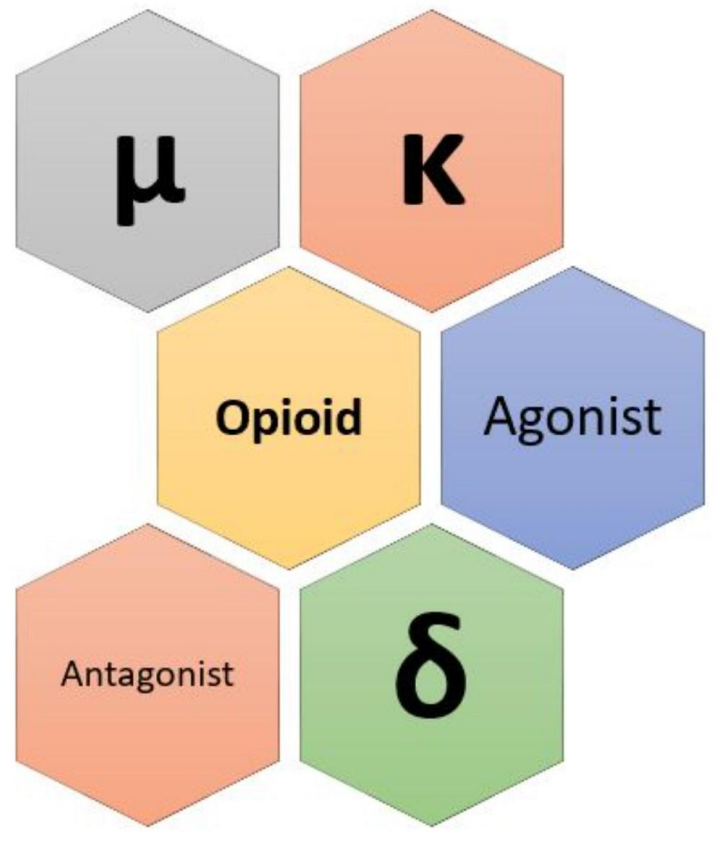
- **Recommendation #11: Benzodiazepines**
  - Use caution when prescribing opioids and benzodiazepines together
  - Up to 4 times increased risk of opioid death
  - Can be prescribed together would require increased monitoring and risk discussion

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

Opioid Equivalence of Morphine 60mg

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

Opioid Receptors



Receptor	Clinical effects	Location
μ	Analgesia Changes smooth muscle tone Sedation Mood alteration Nausea/vomiting	Mesenteric plexus Brain Spinal cord Sub-mucosal plexus
δ	Decreases colonic transit time	Mesenteric plexus Brain
κ	Central analgesia Decreases colonic transit time Visceral nocicep- tion antagonist	Mesenteric plexus Brain Spinal cord

Opioid receptors and their functions.

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

Opioid use disorder DSM-V criteria 2 of 11 within the last year

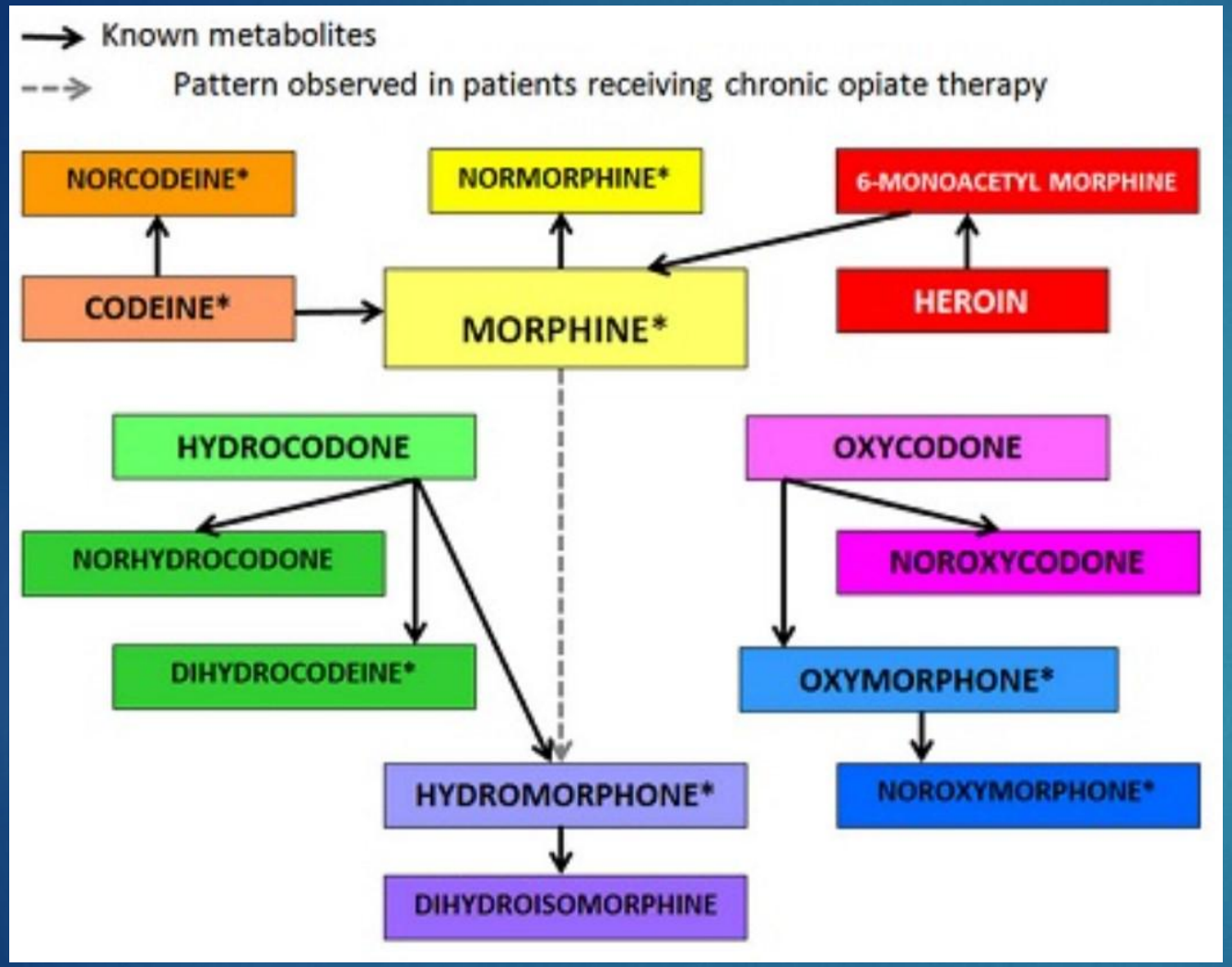
- 1: Opioids are often taken in larger amounts or over a longer period than was intended
- 2: There is persistent desire or unsuccessful attempt to cut down or control opioid use
- 3: A great deal of time is spent in activities necessary to obtain the opioids, use the opioids or recover from its effect
- 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

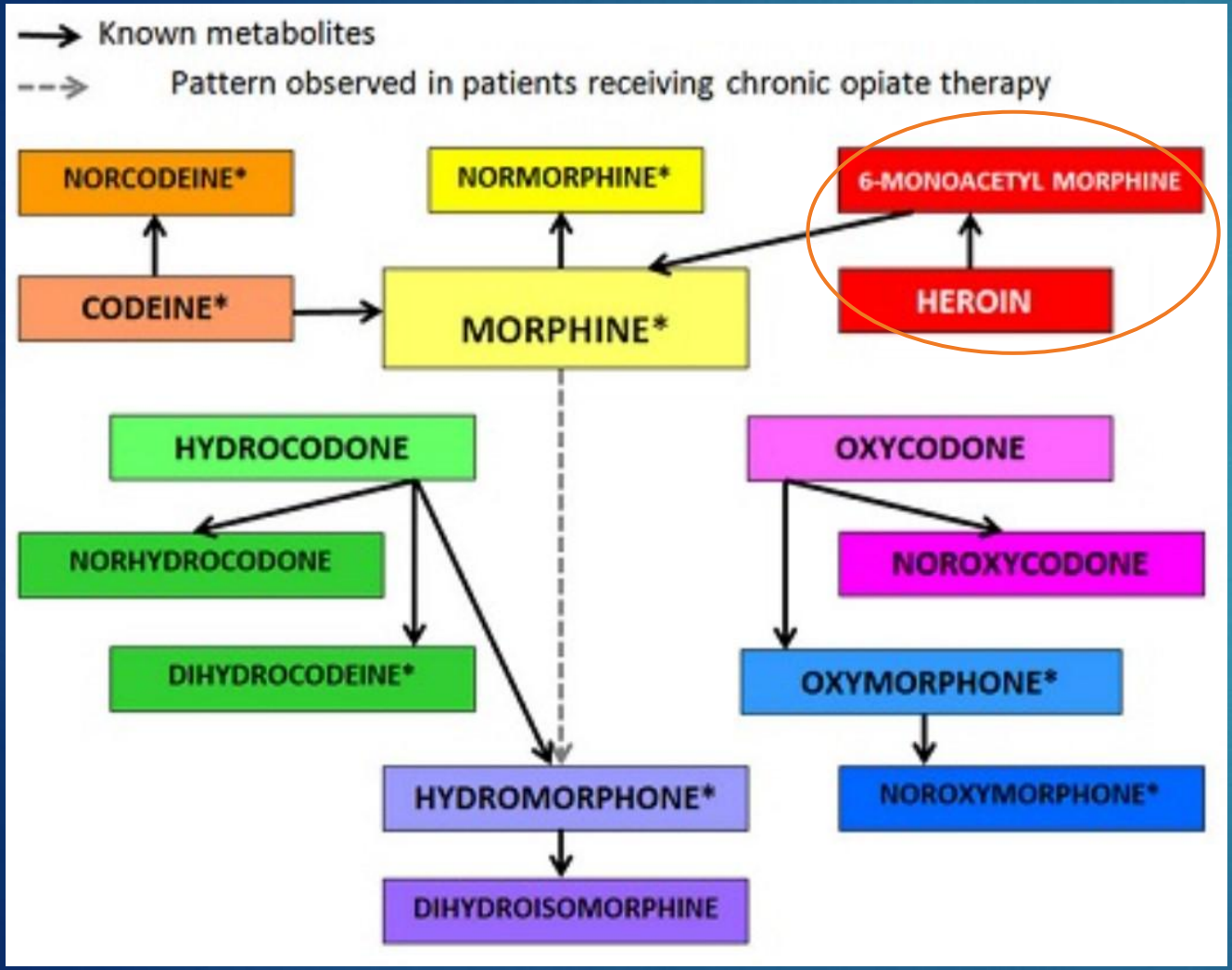
Opioid use disorder DSM-V criteria 2 of 11

- 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

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

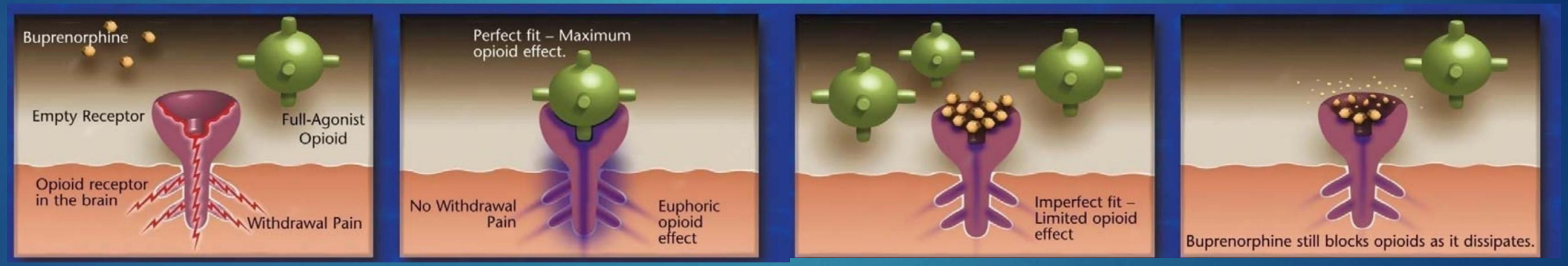
alcohol	7 to 12 hours
amphetamine/methamphetamines	48 hours
Valium	30 days
lorazepam	3 days
marijuana	30 days
morphine oxycodone hydromorphone codeine	2 to 4 days

Ultram (Tramadol)

- Centrally acting synthetic opioid analgesic
- Norepinephrine reuptake inhibitor
- Serotonin reuptake (caution with antidepressants)
- Estimated to be 1/10 of morphine
- Anti-nociceptive effects are mediated by both opioid and non-opioid mechanisms
- Oklahoma PMP: 50 mg=5 milliequivalents of Morphine

Buprenorphine

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



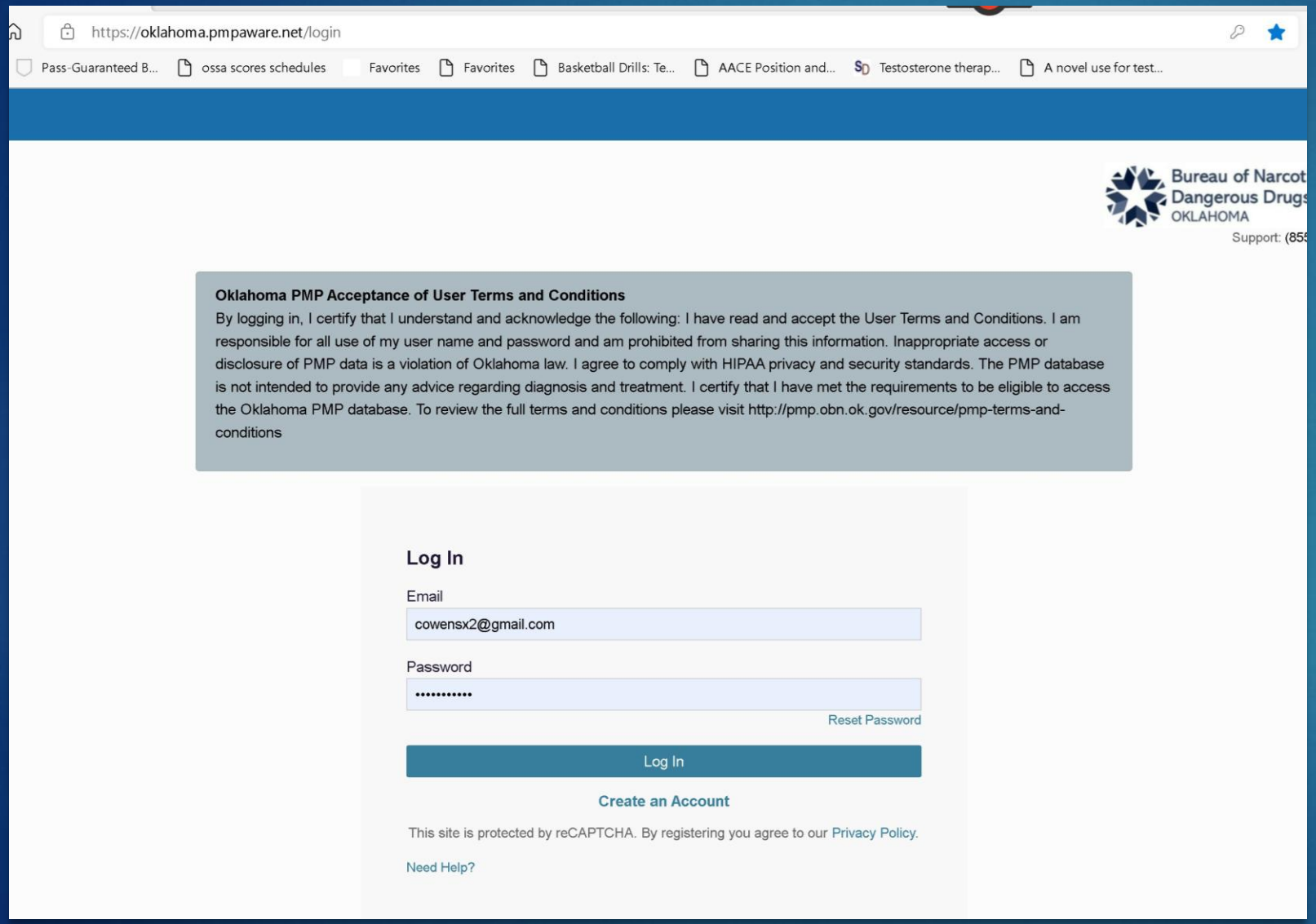
Methadone

- 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

“Tolerance,” “Dependence,” and “Addiction”?

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

Oklahoma
Prescription Monitoring Program (PMP)



- Very useful tool
- SHOWS
  - Prescription
  - Pharmacy
  - Prescribing physician
- Milliequivalents of morphine
- Can assign Delegate

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

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	This prescription can be for 30 days

Chronic Prescriptions i.e., Greater than 3 Months

- Review treatment plan : minimum 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

Patient Provider Agreement Must be Initiated

- At third prescription
- Greater than 100 milliequivalents of morphine per day
- Anytime prescription involves benzodiazepines with opioids
- If patient is pregnant
- 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**

Case Presentation Concerns cont.

- Should query Oklahoma prescription monitoring program
- Should request original doctors note
- Should discuss the obvious lack of effectiveness of opioids
- *Opioid equivalent*
- *Oxycodone 20mg TID*
- *Percocet 10 mg 6 times per day*
  - ***morphine equivalence***

Opioid Prescribing and 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!!