
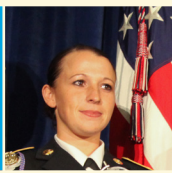
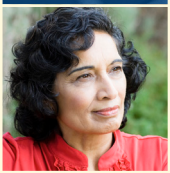
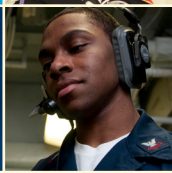


Opioid Therapy for Chronic Pain Pocket Guide

OVERVIEW

Background

This pocket guide is a quick reference tool created for primary care and psychological health providers who administer and direct opioid therapy (OT) treatment services to patients with chronic pain in Department of Veterans Affairs (VA) or Department of Defense (DoD) health care settings. It was developed directly from the 2010 *VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain*. VA and DoD employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.

For more comprehensive information, please refer to the full-length clinical practice guideline (CPG), available at:

- healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp
- https://www.qmo.amedd.army.mil/OT/cot.htm

Target Patient Population:

- Adults (18 or older) with chronic pain conditions who are treated in any VA or DoD clinical setting
- Special populations: polytrauma, traumatic brain injury (TBI), mild traumatic brain injury (mTBI), posttraumatic stress disorder (PTSD), substance use disorder (SUD) and psychiatric health co-occurring conditions

Aims:

- Promote evidence-based management of individuals with chronic pain
- Highlight the critical decision points to manage patients with chronic pain who are candidates for opioid therapy
- Improve patient outcomes (e.g., reduce pain, increase functional status, enhance the quality of life)
- Decrease the incidence of complications
- Allow flexibility so local policies or procedures, such as those regarding referrals to or consultation with substance abuse specialty, can be accommodated

Pocket Guide Tabs

This pocket guide references steps from the following sections within the 2010 VA/DoD CPG, and addresses inter-related aspects of care for patients who manage their chronic pain with OT.

Tab 2	**Assess and Determine the Appropriateness of Opioid Therapy** Includes information from Sections 1 and 2 of the CPG
Tab 3	**Starting the Trial** Includes information from Section 3 of the CPG
Tab 4	**Assess Status and Response to Therapy** Includes information from Section 4 of the CPG
Tab 5	**Adjustment Therapy** Includes information from Section 5 of the CPG
Tab 6	**Consult/Refer and Follow Up** Includes information from Sections 6 and 7 of the CPG
Tab 7	**Discontinue** Includes information from Sections 8 and 9 of the CPG
Tab 8	**Medication Tables** Includes content adapted from the medication table in the CPG
Tab 9	**Black Box Warnings and Resources**

NOTE: The recommendations in the 2010 VA/DoD CPG and this pocket guide are intended to provide information and assist in decision-making. They are not intended to define a standard of care and should not be construed as one. Also, they should not be interpreted as prescribing an exclusive course of management.

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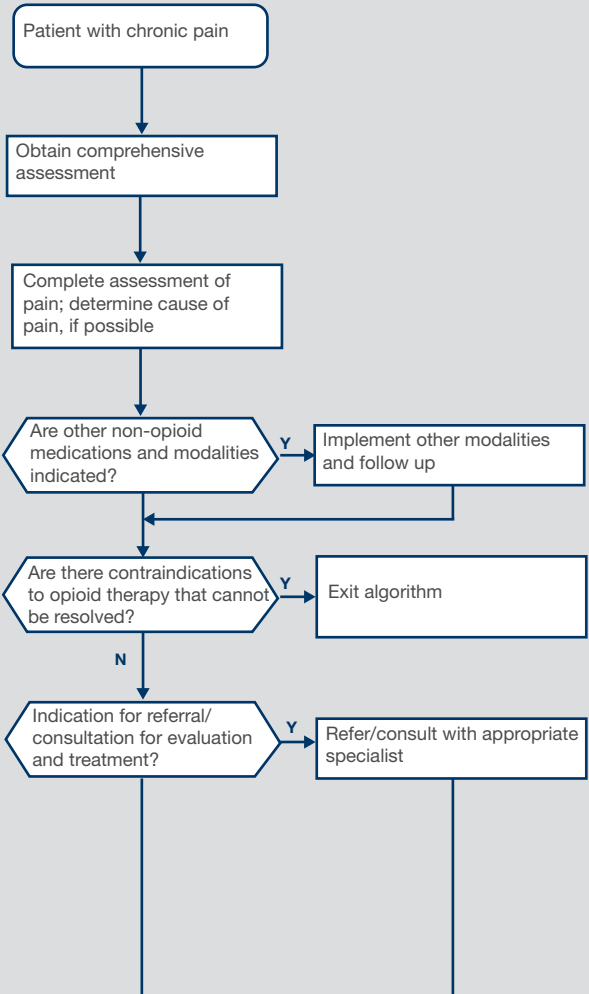
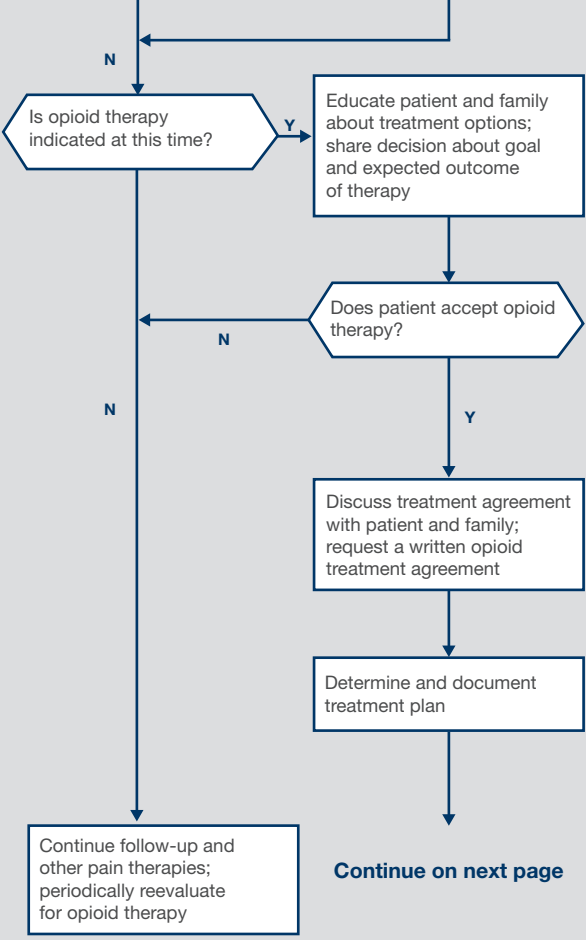

Patient with chronic pain
Obtain comprehensive assessment
Complete assessment of pain; determine cause of pain, if possible
Are other non-opioid medications and modalities indicated?
Y
Implement other modalities and follow up
Are there contraindications to opioid therapy that cannot be resolved?
Y
Exit algorithm
N
Indication for referral/ consultation for evaluation and treatment?
Y
Refer/consult with appropriate specialist



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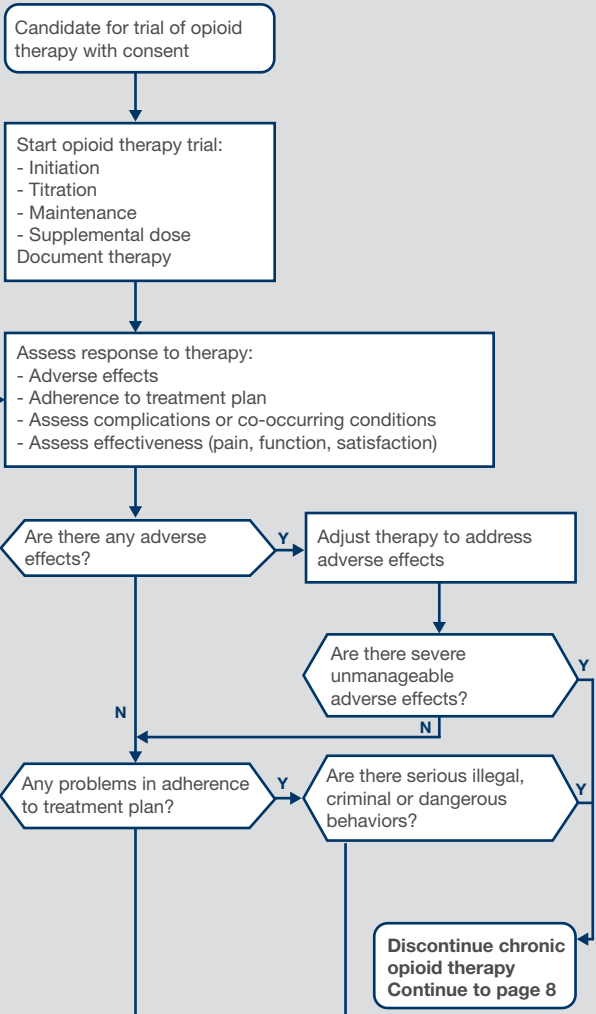
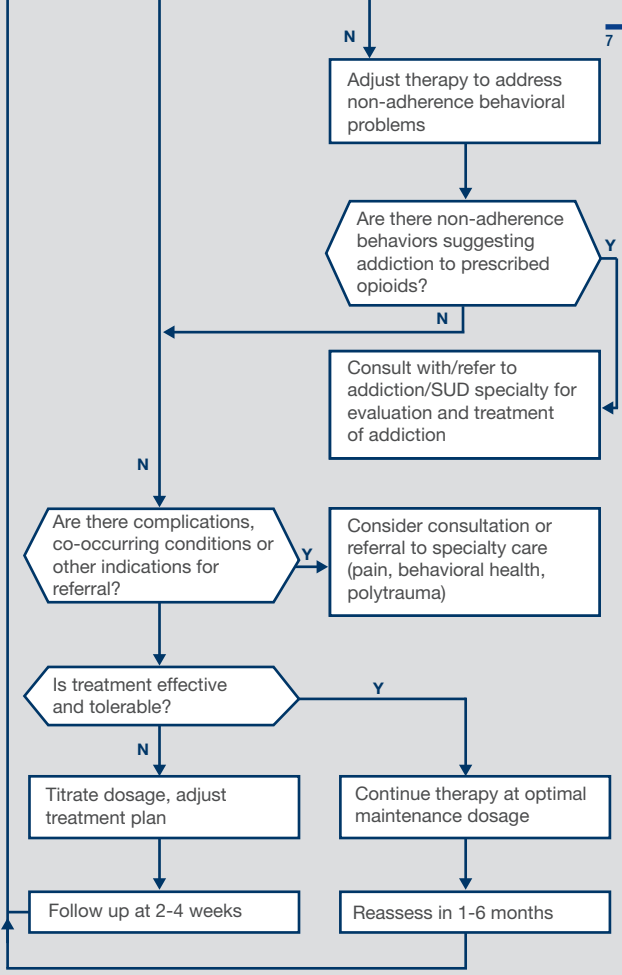
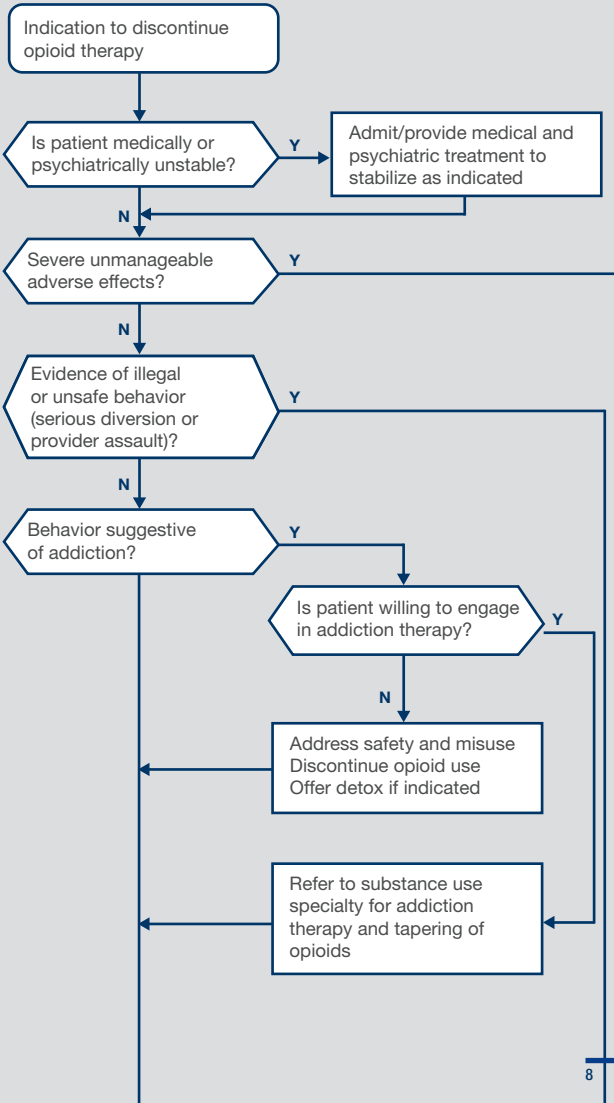

Candidate for trial of opioid therapy with consent
Start opioid therapy trial:
- Initiation
- Titration
- Maintenance
- Supplemental dose
Document therapy
Assess response to therapy:
- Adverse effects
- Adherence to treatment plan
- Assess complications or co-occurring conditions
- Assess effectiveness (pain, function, satisfaction)
Are there any adverse effects?
Y
Adjust therapy to address adverse effects
Are there severe unmanageable adverse effects?
Y
N
N
Any problems in adherence to treatment plan?
Y
Are there serious illegal, criminal or dangerous behaviors?
Y
Discontinue chronic opioid therapy
Continue to page 8


N
Adjust therapy to address non-adherence behavioral problems
Are there non-adherence behaviors suggesting addiction to prescribed opioids?
Y
N
Consult with/refer to addiction/SUD specialty for evaluation and treatment of addiction
N
Are there complications, co-occurring conditions or other indications for referral?
Y
Consider consultation or referral to specialty care (pain, behavioral health, polytrauma)
Is treatment effective and tolerable?
Y
N
Titrate dosage, adjust treatment plan
Continue therapy at optimal maintenance dosage
Follow up at 2-4 weeks
Reassess in 1-6 months


Indication to discontinue opioid therapy
Is patient medically or psychiatrically unstable?
Y
Admit/provide medical and psychiatric treatment to stabilize as indicated
N
Severe unmanageable adverse effects?
Y
N
Evidence of illegal or unsafe behavior (serious diversion or provider assault)?
Y
N
Behavior suggestive of addiction?
Y
Is patient willing to engage in addiction therapy?
Y
N
Address safety and misuse
Discontinue opioid use
Offer detox if indicated
Refer to substance use specialty for addiction therapy and tapering of opioids

Stop opioid therapy
Apply legal mandates
Document in medical record

N

Other indication or patient decision to stop chronic opioid therapy

Educate on withdrawal symptoms
Taper medication

Address alternative treatments for pain
Follow up as indicated

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Assess and Determine the Appropriateness of Opioid Therapy

Tab 2:

ASSESS AND DETERMINE THE APPROPRIATENESS OF OPIOID THERAPY

Step A:

Conduct Assessment

Step B:

Determine the Appropriateness of Opioid Therapy

Step C:

Review Opioid Pain Care Agreement

Step A: Conduct Assessment

Initial Assessment

- Consider opioid trial if:
  - Moderate to severe pain has failed to adequately respond to non-opioid or non-drug interventions
  - Benefits outweigh risks
  - Patient is fully informed and consents
  - Clear and measurable treatment goals are established
  - Patient has no absolute contraindications to OT
- Optimize benefit-to-harm profile

Comprehensive Medical Assessment

- Obtain medical history (e.g., medication, surgical or behavioral health history)
- Obtain social history
- Conduct physical examination (e.g., pain-focused musculoskeletal and neurological exam)
- Obtain pain history
- Use urine drug test (UDT) (also referred to as urine drug screen (UDS)) to screen for the presence of illegal drugs, unreported prescribed medication or unreported alcohol use prior to starting therapy
- Assess suicide risk

Complete Assessment of Pain

(See next page for more information)

- Evaluate pain intensity
- Assess patient's response to current pain treatments
- Assess other attributes of pain
- Determine type of pain if possible
- Assess function
- Review information from pain history and physical exam

Evaluate…	Criteria…
Pain Intensity	■ Assess at each visit ■ Use a standardized rating scale ■ Assess current pain, "least" pain in last week and "usual" or "average" pain in last week
Patient's Response to Current Pain Treatments	■ "What is the intensity of your pain after your current treatment or taking medication?" ■ "How long does your pain relief last after treatment or medication?" ■ "How does treatment or taking medication affect your functioning?"
Other Attributes of Pain	■ Onset and duration, location, radiation, description (quality), aggravating and alleviating factors, behavioral manifestations of pain, and impact of pain ■ Temporal patterns and variations (e.g., diurnal, monthly, seasonal) ■ Current and past treatments for pain ■ Patient's expectations for pain relief
Type of Pain	■ Differentiate between nociceptive and neuropathic pain ■ Consider further evaluation if needed (e.g., imaging, electrodiagnostic studies, consultation) ■ Ask specifically whether the patient suffers from headache(s)
Functional Assessment	■ Cognitive function ■ Employment ■ Enjoyment of life ■ Emotional distress ■ Housework, chores, hobbies ■ Sleep ■ Mobility ■ Self-care behaviors ■ Sexual function

Initial Pain Assessment Tool

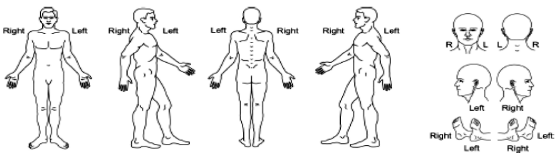
Date_____

Patient's Name_____ **Age**_____ **Room**_____

Diagnosis_____ **Physician**_____

Nurse_____

1. LOCATION: Patient or nurse mark drawing



2. INTENSITY: Patient rates the pain. Scale used _____
Present pain:_____ Worst pain gets: _____ Best pain gets: _____
Acceptable level of pain: _____

3. IS THIS PAIN CONSTANT?__ YES __ NO **IF NOT, HOW OFTEN DOES IT OCCUR?** _____

4. QUALITY: (For example: ache, deep, hot, cold, sensitive skin, sharp, itchy) _____

5. ONSET, DURATION, VARIATIONS, RHYTHMS: _____

6. MANNER OF EXPRESSING PAIN: _____

_____

7. WHAT RELIEVES PAIN? _____

_____

8. WHAT CAUSES OR INCREASES PAIN? _____

9. EFFECTS OF PAIN? (Note decreased function, decreased quality of life)
Accompanying symptoms (e.g., irritability) _____
Sleep_____
Appetite_____
Physical activity _____
Relationship with others (e.g., irritability) _____
Emotion (e.g., anger, suicidal, crying)_____
Concentration_____

10. OTHER COMMENTS: _____

_____

11. PLAN: _____

_____

Step B: Determine the Appropriateness of OT

Assess Contraindications and Determine Setting
(See following page)

- Assess multiple factors prior to initiating therapy
- Consider referral or consultation for evaluation and/or treatment of complicated/complex patients
- Determine appropriate setting for OT

Educate Patient and Family

- Involve patient and family or caregiver in the educational process
- Provide written educational material in addition to discussion (see VA/DoD patient education tool, "Taking Opioids Responsibly")
- Discuss the Opioid Pain Care Agreement (OPCA) in detail (pg. 19)
- Share decisions about goals and expected outcomes of therapy
- Provide and document patient education on the following:
  - General information (e.g., goals, withdrawal symptoms)
  - Patient responsibilities (e.g., keeping medications safe and secure)
  - Legal issues
  - Instructions on how to take medication
  - Prophylactic treatment of adverse effects and management of constipation
  - Comprehensive care plan (e.g., non-pharmacological therapies in addition to OT)

Determine and Document Treatment Plan

- Tailor the treatment plan to the patient's circumstances and characteristics of pain
- Consider the use of other treatment approaches (e.g., biofeedback, cognitive behavior approaches)
- Consider establishing a referral and interdisciplinary team approach if indicated
- Establish a follow-up schedule to monitor treatment and patient progress
- Document treatment plan and patient preferences

The table below summarizes the level of risk and the appropriate OT treatment setting, according to the clinical condition or situation.

Risk of Misuse	Condition/Situation	Treatment Setting for OT
Low	■ No history of SUD ■ No co-occurring psychiatric health disorder ■ Prior good adherence to treatments with the primary care provider ■ Existence of social support system	■ Provide OT in primary care setting
Moderate	■ History of substance use ■ History or co-occurring psychiatric health disorder ■ History of suicide attempt(s) ■ Any positive UDT ■ Any history of legal problems ■ Less than 25 years old	■ Provide OT in primary care setting with escalated monitoring and caution ■ Consider consultation with addiction specialist or behavioral health specialty
High	■ Unstable or untreated substance abuse or behavioral health disorder ■ Persistent or repeated troublesome aberrant behavior or history of aberrant drug related behavior (ADRB)	■ Consider an advanced structured pain clinic or program ■ Co-manage with SUD or behavioral health specialty

CONTRAINDICATIONS OF OT

Absolute Contraindications - Opioid trial should NOT be initiated in the presence of the following:	■ Severe respiratory instability ■ Acute psychiatric instability or uncontrolled suicide risk ■ Diagnosed SUD not in remission and/or active treatment (non-nicotine) ■ Opioid allergy (cannot be resolved by switching agents) ■ Co-administration of drug capable of inducing life-threatening drug-drug interaction ■ QTc interval > 500 milliseconds (for methadone) ■ Active diversion of controlled substances (providing medication to someone for whom it was not intended) ■ Prior opioid trials that were discontinued due to intolerance, non-treatable serious adverse effects or lack of efficacy
Relative Contraindications - Opioid trial can be initiated with caution in the presence of the following:*	■ Co-occuring SUD treatment ■ Medical condition in which OT may cause harm (e.g., sleep apnea, chronic obstructive pulmonary disease (COPD)) ■ QTc interval 450-500 milliseconds (methadone) ■ Paralytic ileus ■ Respiratory depression in unmonitored setting ■ Risk for suicide or unstable psychiatric disorder ■ Complicated pain (e.g., headache not responsive to other pain treatment modalities) ■ Conditions that may impact adherence to OT (e.g., cognitive impairment) ■ Unwillingness or inability to comply with treatment plan (e.g., lack of social support, social instability)

*Relative benefits outweigh risks: consider consultation with appropriate specialty care to evaluate if potential benefits outweigh the risks of therapy.

REFERRALS AND CONSULTS

Refer patient or consider consultation with these providers...	… when these conditions are present
Advanced Pain Provider	■ Complex pain or polytrauma ■ Significant medical comorbidities with a negative impact on OT ■ Situation requires management beyond comfort or experience of the provider ■ Opioid-induced hyperalgesia or opioid tolerance is suspected ■ High doses of medication provide no further improvement in function ■ Inability to tolerate increased pain or physical withdrawal symptoms arising from opioid tapering when OT is discontinued
Substance Use Disorder Specialist	■ Has an active SUD (exclude nicotine) ■ Has difficulty tolerating opioids or is unable to tolerate taper to discontinue OT ■ Presents with behaviors suggestive of opioid abuse or addiction to either opioids or other drugs. These include: – Rapidly escalating demands for dose increases or unusual increase in doses – Observed or reported intoxication or unexplained withdrawal symptoms – Frequent reports that opioid medication was lost, stolen or destroyed – Opioid use in ways other than as prescribed (e.g., snorting, injecting) – Threats or harrassment of staff – Repeatedly seeking prescriptions from other providers or emergency departments – Alteration, theft, sale of prescriptions or use of someone else's prescription

REFERRALS AND CONSULTS, continued

Refer patient or consider consultation to these providers…	… when these conditions are present
Behavioral Health Specialist	■ Exacerbation of an underlying behavioral health disorder ■ Uncontrolled, severe behavioral health disorder or emotional instability ■ Demonstration of high-risk behaviors or verbalization suggestive of suicidal ideation ■ Psychosocial problems or comorbidities that may benefit from case management ■ Adverse behavioral or cognitive effects of OT ■ Co-occurring trauma related conditions (e.g., traumatic brain injury, PTSD) ■ Expressed interest in alternative approaches ■ Current behavioral health provider's recommendation
Neurologist	■ Headaches ■ Indications of memory loss ■ Loss of cognitive function
Occupational Health Specialty Provider	■ Patient's occupation requires high level of cognitive function

Step C: Review Written Opioid Pain Care Agreement

- The Opioid Pain Care Agreement (OPCA) is an agreement between the providers and the patient regarding provision of OT as part of care for chronic pain.
- The use of the term “contract” should be avoided, since it is not a legal document.
- The provider should obtain informed consent, including discussion of risks, benefits and conditions under which opioids are prescribed.
- The provider should discuss a trial of OT with the patient and obtain the patient’s informed consent in a shared decision-making discussion.
- The provider should document all contact with the patient, including discussions of informed consent and patient refusals to sign the OPCA.

Sample OPCA [CPG, APPENDIX C]

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain to improve my ability to function. Chronic OT is only ONE part of my overall pain management plan.

2. I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the suspension of OT.

3. I understand that the most common adverse effects of OT include constipation, nausea, sweating and itchiness of the skin. Drowsiness may occur when starting OT or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

4. I will not seek opioid medications from another physician for the treatment of my chronic pain. Regular follow-up care is required and only my provider will prescribe these medications for my chronic pain at scheduled appointments.

5. I will attend all appointments, treatments and consultations as requested by my providers. I will attend all pain appointments and follow pain management recommendations.

6. I will not give or sell my medication to anyone else, including family members, nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. If these medications are stolen, I will report this to police and my provider and I will produce a police report of this event if requested to do so.

7. I understand that if my prescription runs out early for any reason (e.g., if I lose the medication or take more than prescribed), my provider may not prescribe extra medication for me. I may have to wait until the next prescription is due.

8. I understand that the use of other medications can cause adverse effects or interfere with OT. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me (tranquilizers) and all illicit drugs.

9. I agree to periodic unscheduled drug screens.

10. I understand that I may become physically dependent on opioid medications which, in a small number of patients, may lead to addiction. I agree that, if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.

11. I understand that my failure to meet these requirements may result in my provider choosing to stop writing opioid prescriptions for me. Withdrawal from the medications will be coordinated by the provider and may require specialist referrals.

12. I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

13. My providers may obtain information from state controlled substances databases and other prescription monitoring programs.

Patient Signature:_____

Starting the Trial

Tab 3:

STARTING THE TRIAL

Step A:

Initiation

Step B:

Titration

Step C:

Maintenance

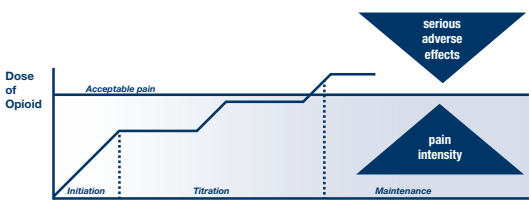
Step D:

Supplementation

OVERVIEW

- A trial of OT consists of three phases: initiation, titration and maintenance:
  - The **initiation (step A in this tab)** phase involves the selection of an appropriate opioid and dose for the individual patient, obtained in the comprehensive assessment.
  - The **titration (step B in this tab)** phase involves adjustment of the dose to achieve the desired clinical outcomes (e.g., pain relief, improved function and patient satisfaction with minimal or tolerable side effects). The clinically appropriate dose yields maximum pain relief with minimal intolerable or unmanageable adverse side effects.
  - During the **maintenance (step C in this tab)** phase, the patient's required daily dose remains relatively stable. This may be the longest phase of the OT trial.
- **Supplemental (step D in this tab)** doses of non-opioids, short-acting opioids or both should be considered during treatment.

Opioid Therapy – Titrate to Effect



It is important to document therapy at all times, according to clinical guidelines, local policy and legal requirements. When writing a prescription for an opioid, remember to record:

- Name of the drug
- Strength of the drug
- Number of dosage units (written numerically and in text)
- How the drug is taken

Step A: Initiation

General Strategy

- Chronic pain is often a complex biopsychosocial condition. Clinicians who prescribe OT should routinely integrate psychotherapeutic interventions, functional optimization, interdisciplinary therapy, and other adjunctive non-opioid pain therapies.
- Document written and verbal patient education regarding medication and adverse effects such as excessive sedation. (See pg. 31 for additional adverse effects)
- Obtain UDT, with patient consent, prior to initiating therapy and randomly during follow-up visits
- Start the OT trial with a low dose and one medication at a time
- Initiate bowel regimen to prevent and treat constipation

Strategy for Continuous, Persistent Daily Pain

- Use an agent with a long duration of action (see pg. 60)
- Alternatively, start short-acting opioids first and later convert to long-acting opioids
- Initiate treatment with opioids on a scheduled basis

Strategy for Episodic Pain

- Try one short-acting opioid at a time as needed (see pg. 57)
- Do NOT use long-acting opioids on a PRN basis

Methadone

Methadone is a synthetic agent with a long duration of action that comes in tablet and liquid forms. It is sometimes recommended for treating continuous chronic pain. The analgesic action lasts six hours or longer, but can take one to two weeks to stabilize. Methadone has a long half-life, with a possibility of accumulation and delayed toxicity without continued analgesic effect; it is also high in toxicity. Methadone is complicated in its pharmacokinetic and pharmacodynamic properties and should be prescribed with caution by clinicians who are familiar with methadone's titration and risks, or those who are able to consult with a physician experienced in methadone treatment.

Methadone Dosing for Chronic Non-cancer Pain (CNCP)

- Start low, go slow! Start with low initial dose, adjust conversion ratios to prior opioid use and titrate slow to patient's response.
- For patients not on previous opioids: Initial dose 2.5 mg every eight to 12 hours, with titration increment of five to seven days.
- Initial doses of methadone should be small and adjusted to the previous opioid use, using smaller methadone-to-morphine-equivalent conversion ratios (%) the larger the previous morphine-equivalent dose.
- Close patient monitoring is required (weekly during titration, monthly during maintenance).

METHADONE

Dosing strategy	Gradual titration (for CNCP and situations necessitating less frequent monitoring)
Initial MET dose	2.5 mg every eight to 12 hours
Increments	2.5 mg every eight hours every five to seven days
Comments	As a general rule, start low and go slow

Note: Patients should be warned about potential adverse effects and possibility that these may evolve during treatment, especially after each dose adjustment.

Adverse Effects and Caution

- Drowsiness: avoid use with other central nervous system (CNS) depressants, sedatives and alcohol; advise caution when driving or operating machinery.
- Respiratory depression: use extreme caution with asthma, COPD, cor pulmonale, severe obesity and obstructive sleep apnea (OSA).
- Corrected QT (QTc) prolongation: monitor patients with increased risk of dysrhythmia, conduction abnormalities or medication affecting cardiac conduction.
- Use additional caution in elderly (> 65) and patients with liver and renal disease.

Methadone Patient Education

- Explain to patients that the initial dose may not provide optimum pain relief, but is chosen in order to reduce the chance of adverse effects. Advise patients to keep a pain diary to monitor patient response.
- Reassure patients that the dose will be titrated to achieve adequate analgesia.
- When applicable, explain how to use the short-acting opioid during methadone dose titration, and advise not to use methadone on an as-needed basis.
- Advise patients that the effect of methadone is not immediate but will strengthen in the week following dose increase. Pain relief during the last few days of that week will be greater than in the first few days of the week.
- Remind patients about the need for frequent monitoring during the titration and maintenance periods. Provide patients with instructions on what to do if they develop increasing or intolerable adverse effects.
- Advise patients to avoid abrupt discontinuation of their opioid medication without first consulting their physician. Educate patients about withdrawal symptoms.
- Some patients may worry that others will perceive their use of methadone as evidence of a possible addiction to or dependence on opiates. Explain the difference between the therapeutic use of methadone and addiction or dependence.
- Inform the patient that the goal of treatment is to reduce pain and improve physical, emotional and/or social functioning. The provider may also want to inform the patient that the elimination of pain may not be possible.

The checklist below lists steps and considerations for prescribing methadone.

Using Methadone Checklist:

- ☐ Inform patients of arrhythmia risk
- ☐ Ask patients about heart disease, arrhythmia, syncope and sleep apnea
- ☐ Educate patients about drug interactions
- ☐ Obtain an ECG to measure the QTc interval before starting methadone and once the dose is stabilized
- ☐ Measure the QTc annually thereafter if the patient history is positive for risk factors for prolonged QTc interval or has known prolonged QTc interval
- ☐ Perform additional ECG if the methadone dosage exceeds 100 mg/day, or if the patient has unexplained syncope or seizures
- ☐ Reevaluate and discuss the potential risks and benefits of therapy and the need to monitor the QTc more frequently if the interval is greater than 450 ms and less than 500 ms
- ☐ Discontinue or taper the methadone dose and consider alternative therapy if the QTc interval is greater than 500 ms. Whenever possible, eliminate other contributing factors, such as drugs that cause hypokalemia or QT prolongation
- ☐ Be aware of interactions between methadone and other drugs that may prolong QTc interval or slow the elimination of methadone

Step B: Titration

Once OT starts, providers should follow up with patients every two to four weeks after any medication, dose or treatment change and every one to six months during the maintenance phase. During these visits, providers need to assess pain control, adverse effects, adherence with the OT treatment plan, signs of addiction, tolerance, dependence and signs of illegal use. The goal is to determine whether OT is still a safe and beneficial option.

Documentation is essential and should demonstrate the evaluation process – to include consultation, prescriptions and periodic review of patient status. Communicate closely with patients and families. As with initial opioid selection, set dose levels on patient need, not predetermined maximal dose.

General Strategy

- Follow up with patient no longer than two to four weeks after dose modifications or treatment adjustments
- Assess for changes in biopsychosocial and spiritual domains
- Adjust the daily dose by 25-100 percent at a time, if necessary
- Do not increase more than every five half lives (for methadone or fentanyl no more than once a week)
- Titrate only one drug at a time
- Increase medication until limited by adverse effects or lack of efficacy
- Consider reasonable supplemental doses of short-acting opioid

Converting Short-acting to Long-acting Opioids

- Use an agent with a long duration of action for chronic pain
- Base conversion on an equianalgesic conversion (see pg. 29)
- Start the conversion dose at 50-67 percent of the calculated equianalgesic dose, given the incomplete cross-tolerance between opioids

OPIOID ROTATION

For continuous chronic pain, an agent with a long duration of action such as morphine controlled-release (CR), oxycodone CR or transdermal fentanyl is recommended. If short-acting opioids are found to be effective with minimal side effects when treating continuous pain, consider substituting the short-acting opioid with an equivalent dose of a long-acting formulation. Long-acting opioids can also be accompanied by brief doses of short-acting opioids to control intensifying pain.

Opioid rotation may help improve efficacy, reduce side effects and reduce dose escalation in patients who are receiving long-term OT. Consider:

Step-wise rotation	Single-step rotation
Reduce the old opioid dose by 25-50 percent	Stop the current opioid
Replace the amount removed with an equianalgesic conversion of the new opioid	Start the new opioid dose
Preferable when switching large doses of opioids	Preferable when an opioid must be stopped immediately because of a hypersensitivity reaction

When converting from one opioid to another, follow these seven steps (Consider referral to a pain specialist for high doses of medication):

1. Determine the total 24-hour dose of the current opioid.
2. Calculate the equivalent dose of new analgesic for the desired route of administration using the estimated equianalgesic dose in the table below step 7.
3. Keep in mind, for most agents, when converting to a different opioid, the starting conversion dose of the new opioid should be 50-67 percent of the equianalgesic dose due to incomplete cross-tolerance. A notable exception to this general rule is methadone. Inexperienced clinicians should consult with an expert before initiating methadone, even in an opioid-tolerant patient.

4. Take the 24-hour starting dose of the new opioid and divide by the frequency of administration to give the new dose for the new route.
5. Base the method of rotating opioids (step-wise or single-step rotation) on the clinical situation.
6. Consider rescue OT during the conversion process.
7. Remind patients about the need for and the frequency of monitoring: at least once per week during titration and at least once a month during maintenance.

Equianalgesic and conversion doses for patients previously receiving other opioids

Opioid Agent	Estimated Oral Equianalgesic Dose (Mg)	Initial Conversion Dose (Not Equianalgesic)†	
Codeine	180 to 200‡	30 mg q 4 to 6h	
Fentanyl	— (transdermal)	For converting ONLY to fentanyl from another opioid, use about 12 mcg/h fentanyl transdermally for every 45 mg of oral morphine or equivalent (see Table E7 of CPG: Initial Fentanyl Transdermal Dosage)	
Hydrocodone	30	50-67% of estimated oral equianalgesic dose	
Hydromorphone	7.5	50-67% of estimated oral equianalgesic dose	
Methadone	20 acute 2 to 4 chronic	Methadone-to-morphine dosage proportion (%) is dependent on morphine-equivalent dose of previous opioid For gradual conversion to methadone:	
		Oral morphine	**Methadone**
		< 200 mg/d	5 mg q 8 h
		200 to 500 mg/d	~7% of oral morphine-equivalent dose, given in divided doses q 8 h
		> 500 mg/d	See *Methadone Dosing Recommendations for Treatment of Chronic Pain* Consider consultation with a pain specialist, clinical pharmacist, or other practitioner who has experience with using methadone for chronic pain

Equianalgesic and conversion doses for patients previously receiving other opioids (cont).

Opioid Agent	Estimated Oral Equianalgesic Dose (Mg)	Initial Conversion Dose (Not Equianalgesic)†
Morphine	30	50-67% of estimated oral equianalgesic dose
Oxycodone	15 to 20§	50-67% of estimated oral equianalgesic dose
Oxymorphone	10	50-67% of estimated oral equianalgesic dose
Tapentadol	No data (50 to 100‡)	50 to 100 mg q 4 to 6 h
*Tramadol	No data (100 to 150‡)	25 mg every morning

*May 25, 2010 the Food and Drug Administration (FDA) strengthened the Warnings section of the prescribing information for tramadol to emphasize the risk of suicide in patients who are addiction-prone or taking tranquilizers or antidepressant drugs, and to warn of the risk of overdosage.

Many other equianalgesic dosing tables are available that may provide equivalent doses different from those shown here.

† The initial dose of the new drug applies to patients who are not tolerant to the new opioid and should be given at 50-67% of the calculated dose for all potent opioids except fentanyl and methadone to allow for incomplete cross-tolerance (the new drug may have more relative analgesic efficacy and more adverse effects). For methadone, use dosage proportions (%) based on the morphine-equivalent dose of previous opioid (also see *Methadone Dosing Recommendations for Treatment of Chronic Pain*). Initial doses should be individualized. The patient's medical condition, the potency, dose, and type of previous opioid, the patient's degree of opioid exposure and tolerance, the patient's past analgesic response and adverse experiences, and the accuracy and reliability of opioid conversion factors may all influence the choice of starting dose.

‡ When converting from weak opioid analgesics to stronger opioids, use the recommended initial doses of the new opioid for opioid-naive patients. Doses of tapentadol and tramadol should NOT be considered equianalgesic to the doses of pure agonists. Equianalgesic doses have not been established for conversions between either tapentadol or tramadol and pure opioid agonists.

§ Exceeds recommended initial dose (oxycodone 5 mg)

Step C: Maintenance

Maintain

- Maintain the lowest effective and tolerated dose
- Obtain optimal dose by achieving pain reduction and/or improvement in functional status and patient satisfaction with tolerable side effects
- Recognize the dose may be titrated based on the patient's current biopsychosocial situation

Assess

- Assess the frequency of follow-up depending on adverse effects, pain status and appropriate use of medication
- Assess at least every one to six months based on:
  - Patient characteristics, comorbidities, potentional drug misuse, type of pain and dose of opioids
- Patient should be able to request an early evaluation
- Any change in the efficacy of the maintenance dose requires a face-to-face encounter

Renew and Follow Up

- Reminders with monthly medication renewals:
  - Structured program (e.g., opioid renewal clinic) staffed by advanced care providers with appropriate co-signatures
  - Phone call, email or mail-in requests
- Reassess and re-educate patients about how to safely store opioid medications

Step D: Supplementation

Supplemental short-acting opioids may be considered in specific situations as needed for rescue, break-through pain or incident pain.

Type of Therapy	Description of Pain Episode	Recommendations
Rescue	Insufficient analgesia during dosage titration	■ Use rescue short-acting opioids to assist with pain management during the titration process ■ Use rescue short-acting opioids to help determine the long-term daily opioid dose
Breakthrough Pain	Unpredictable exacerbation of chronic pain otherwise controlled on stable maintenance doses of opioid	■ Use sparingly, if necessary ■ Do not use routinely for chronic pain ■ Consider adjusting the long-acting opioid regimen if pain exacerbations are interfering with function due to severity, frequency or diurnal variations in pain intensity
Incident Pain	Predictable, activity-related exacerbation of chronic pain otherwise controlled on stable maintenance doses of opioid	■ Educate and reassure patient ■ Emphasize realistic expectations about limitations of chronic OT, the normal cyclic nature of chronic pain and the importance of pacing activities ■ Consider pre-emptive analgesia for preventing incident pain (e.g., 8-12 doses/month of short-acting opioid preparation)

Assess Status and Response to Therapy

Tab 4:

ASSESS STATUS AND RESPONSE TO THERAPY

Step A: Assess Side Effects

Common Side Effects	Keep in Mind
■ confusion ■ constipation ■ dizziness ■ dry mouth ■ dyspepsia ■ headache ■ hyperalgesia ■ endocrine dysfunction ■ nausea and vomiting ■ pruritus ■ sedation ■ sexual dysfunction ■ sweating ■ tiredness ■ tolerance	Many side effects spontaneously resolve with development of tolerance Anticipate and consider preventive treatment for common side effects Slowly titrate the opioid dose, modify the dosage regimen, treat symptoms and rotate the opioid agents to successfully treat most side effects Consider possible drug-to-drug interactions with other medications that have been prescribed for the patient

Step B: Assess Adherence

The goal of this step is to determine whether the patient is adhering to the essential components of the treatment plan. Determination of any reasons for non-adherence requires a thorough evaluation.

PREDICTORS OF OPIOID MISUSE

Strong Predictors

- History of alcohol and illicit substance abuse

Moderate Predictors

- Less than 25 years old
- History of legal problems
- Positive UDT (informed consent example follows)

Weak Predictors

- Family history of SUD
- History of childhood sexual abuse
- History of DUIs or drug convictions
- Lost or stolen prescriptions
- History of obtaining opioids from alternate sources
- High scores on Screener and Opioid Assessment for Patients with Pain (SOAPP) or Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)

Inconsistent Predictors

- Male
- History of an anxiety disorder
- History of prescribed drug abuse
- Race (non-white)
- Level of education
- History of motor vehicle accidents
- History of schizophrenia

NON-ADHERENCE TO OT

Possible Reasons for Non-adherence	■ Poor provider-patient communication ■ Addiction or pseudo-addiction ■ Confusion and/or memory impairment ■ Psychiatric disorders ■ Emotional distress ■ Pursuit of financial gain
Aberrant Drug-related Behaviors (ADRBs)	■ Patients on OT can develop problems with adhering to the treatment plan, also called ADRBs ■ Minor ADRBs: behaviors that do not immediately jeopardize health or safety, but may negatively impact treatment effectiveness ■ Serious ADRBs: variations are those that are illegal or jeopardize the safety of the patient or society
Levels of Non-adherence	■ Level I: relatively minor variations to prescribed medication schedules, asking for early refills, misplacing medications, and lending and borrowing medications from others ■ Level II: behaviors that persistently demonstrate deviation from the treatment agreement and represent manifestations of serious comorbidities such as addiction, mood disorders, personality disorder, PTSD, psychosis or cognitive dysfunction ■ Level III: illegal, criminal or dangerous behaviors
Evaluating Non-adherence	■ Assess and document patient motivation and barriers to adherence at every visit ■ Consider use of screening aids such as random pill counts, adherence checklists or instruments such as the SOAPP ■ Obtain a UDT randomly, with patient consent, at follow-up visits to confirm appropriate use of opioids ■ Assess patients for behaviors that are predictive of addiction, including repeated minor variations in adherence, which may indicate an increased likelihood of addiction or serious non-adherence ■ Consult with SUD or behavioral health specialist

UDT Informed Consent

- Inform patients that drug testing is a routine procedure for all patients who start or are on OT and is an important tool to monitor the safety of their treatment.
- With patient consent, obtain a UDT on all patients prior to initiation of OT.
- With patient consent, monitor all patients on OT with periodic random UDTs to confirm adherence to the treatment plan. Increase the frequency of UDTs based on risk level for aberrant drug-related behaviors and following each dose increase.
- Take into consideration a patient's refusal to take a UDT as part of the ongoing assessment of the patient's ability to adhere to the treatment plan and the level of risk for adverse outcomes.
- Take into account other clinical information (e.g., past SUD, aberrant drug-related behaviors and other conditions indicating risk) when interpreting UDT results.
- Interpret UDT results with an understanding of specific lab methods for drug testing and reporting. Maintain a close working relationship with the clinical laboratory to answer any questions about the UDT or to confirm the results.

Step C: Assess or Identify any Complications

Evaluate for the following problems:
☐ Patient with complex pain conditions (e.g., dysfunction in the nervous system, polytrauma)
☐ Patient with significant medical comorbidities that may negatively impact OT
☐ Patient with significant concurrent psychiatric illnesses
☐ Patient with inability to tolerate increased pain or physical withdrawal symptoms arising from opioid tapering when therapy is being discontinued
☐ Patient with opioid-induced hyperalgesia or opioid tolerance suspected
☐ Patient with conditions that require management beyond the expertise level of the primary provider

If any of the above are noted, consider consultation/referral with SUD or behavioral health specialist.

Step D: Assess Overall Effectiveness

Pain

- Evaluate pain intensity at each visit
- Measure pain intensity with a Numeric Rating Scale (NRS) and include the following:
  - Current pain
  - Most and least pain in the last week
  - "Usual" or "average" pain in the last week

Objective Documentation to Evaluate Function

- Evaluate pain-related function using objective documentation on a monthly basis during the titration phase and every six months after the patient is stable on opioids:
  - Physical therapy progress notes
  - Employment records
  - Exercise diaries
  - Family reports
  - Clinician observations
  - NRS rating scales
- Evaluation should occur on a monthly basis during titration and every six months after patient is stable on OT

Assessment of Function

- Assess overall patient function related to pain at each visit. Areas of concern should include:
  - Employment
  - Enjoyment of life
  - Emotional distress (depression and anxiety)
  - Housework, chores, hobbies and other day-to-day activities
  - Sleep
  - Mobility
  - Self-care behaviors
  - Sexual function

Satisfaction

- Assess overall patient satisfaction with therapy at each visit

Adjustment Therapy

Tab 5:

ADJUSTMENT THERAPY

Step A:

Address Side/Adverse Effects

Step B:

Address Serious Non-adherent Behaviors

Step C:

Address Minor Non-adherent Behaviors or Medication Misuse

Step D:

Address Moderate Non-adherence

Step A: Address Side/Adverse Effects

Manageable Side Effect Protocol

- Provide low starting doses, slow titration rates, prophylactic and symptomatic treatments and specific patient education at the beginning of treatment
- Augment symptomatic treatment with slow dosage titration, dose modification and/or opioid rotation to minimize the side effects as follows:
  - Titrate slowly or modify dosage regimen to allow patient to develop tolerance to side effects
  - Consider rotation to another opioid agent if these measures fail to minimize side effects
- Discontinue therapy if side effects are unmanageable and therapy is of greater detriment than benefit to patient, as determined by discussion with patient and family

Adverse Effect Protocol

- Determine whether occurrence of adverse effects warrants an adjustment or discontinuation of therapy
- Manage adverse effects
- Manage co-occuring conditions

Other Safety Measures

- Consider change to an alternate opioid medication if medication causes unmanageable adverse effects
- Discontinue opioid therapy when therapy is of greater detriment than benefit to patient

EXAMPLES OF MANAGEABLE SIDE EFFECTS:

Treating Pruritus

- Rule out an allergic reaction
- Consider treatment with antihistamines:
  - Itching may resolve spontaneously despite continuation of therapy

Treating Sedation

- Rule out other causes
- Reduce or temporarily hold dose with or without addition of co-analgesic to prevent respiratory depression
- Add or increase non-sedating adjuvant for additional pain relief
- Consider rotating to another opioid agent if above measures fail
- Consider adding caffeine or a prescription psychostimulant medication

Treating Constipation

- Initiate bowel stimulant and increase liquids, fiber and exercise:
  - NOTE: Bulk-producing laxatives (e.g., psyllium, polycarbophil) are not recommended
- If initial regimine is not effecive, consider adding mild hyperosmotic, saline and emollient laxatives if bowel stimulant is not enough
- Reduce/discontinue other drugs that may cause constipation if possible
- Assess for constipation symptoms at every visit

MANAGEMENT OF ADVERSE EFFECTS

Adverse Effects	Signs and Symptoms	Protocol for Management
Respiratory Depression	■ Drowsiness ■ Slow-shallow breathing ■ Difficulty staying awake ■ Problems awakening ■ Loud or unusual snoring	■ Administer the lowest effective opioid dose necessary to achieve satisfactory pain control. Start low and go slow ■ Avoid other CNS depressants, especially benzodiazepines, because this combination has been identified in opioid related deaths ■ Alert family members or caretakers of the important warning signs to watch for which may indicate that the opioid should be decreased or stopped: – Difficulty staying awake – Difficult or slow breathing – Loud or unusual snoring at night – Difficulty awakening
Opioid-induced Endocrinopathy	■ Loss of libido ■ Impotence ■ Fatigue ■ Mood alterations ■ Loss of muscle mass and strength ■ Abnormal menses ■ Infertility	■ Ask all patients on opioids about symptoms of opioid-induced endocrinopathy (e.g., hypogonadism) on each visit ■ Determine the causes for symptoms through consideration of additional conditions, labs and/or consultation with an endocrinologist ■ Insufficient data exists to recommend routine laboratory screening for endocrinopathy in asymptomatic patients on OT ■ Consider testosterone patch therapy, as research indicates it may improve androgen deficiency symptoms, sexual function, mood, depression and hematocrit levels

MANAGEMENT OF ADVERSE EFFECTS, continued

Adverse Effects	Signs and Symptoms	Protocol for Management
Hallucinations/ Dysphoria	■ Confusion ■ Bad dreams ■ Hallucinations ■ Restlessness ■ Agitation ■ Myoclonic jerks ■ Significantly depressed level of consciousness ■ Seizures	■ Evaluate underlying cause; consider role of primary therapy. Hallucinations can be due to a variety of causes, including change in surroundings and sleep deprivation ■ Evaluation of hallucinations is often performed by "trial and error" techniques. Eliminate nonessential CNS acting medications (e.g., steroids) ■ Re-evaluate and treat underlying process if appropriate ■ Dysphoria is more common with mixed opioid agonists/antagonists and antidopaminergic medications ■ If hallucination or dysphoria persists: – Consider a trial of an antipsychotic in consultation with behavioral health specialist – Switch to another opioid
Sleep-disordered Breathing	■ Loud snoring ■ Fatigue ■ Excessive daytime sleepiness ■ Morning headaches (cerebral vasodilation) ■ Depression and/or emotional instability ■ Short-term memory loss ■ Impaired concentration ■ Irregular pauses in breathing	■ Strongly consider discontinuation of OT and obtain sleep studies. Central sleep apnea is a relative contraindication to OT. Discontinuation of OT should be considered if sleep apnea is severe or life-threatening ■ Instruct patients to avoid alcohol and medications that cause drowsiness ■ Instruct patients with obstructive sleep apnea to sleep on their side and use nasal sprays to help keep their throat and nasal passages open ■ Suggest to the patient that it may be helpful if his/her dentist or orthodontist can create a specifically designed mouthpiece or oral appliance

MANAGEMENT OF ADVERSE EFFECTS, continued

Adverse Effects	Signs and Symptoms	Protocol for Management
Osteoporosis	■ Often goes undetected until bone fracture	■ Consider monitoring bone density in patients at risk for osteoporosis as patients with fractures associated with hypogonadism often have no other symptoms
Immune Dysfunction	■ Severe fatigue that impairs function ■ Difficulty concentrating and short-term memory loss ■ Pain in the joints and muscles ■ Decreased Ig (immunoglobulins) in chronic pain patients before starting treatment and further decreased during OT ■ Symptoms that worsen following strenuous physical or mental exertion within last 12-48 hours	■ Obtain labs to rule out immune dysfunction and consultation with immunologist ■ There is insufficient evidence to make recommendations regarding OT and immune dysfunction

MANAGEMENT OF OPIOID THERAPY COMPLICATIONS

Complication	Signs and Symptoms	Protocol for Management
Opioid-induced Hyperalgesia (OIH)	■ Increased pain or pain sensitivity without change in medical condition	■ May be managed by OT taper or discontinuation ■ Expect a paradoxical reduction in pain with reduction in opioid dose
Opioid-induced Tolerance	■ Decreased sensitivity to opioids (larger doses required to achieve same effect) ■ Decreased pain relief at a stable dose of medication	■ Patients who have developed tolerance will have improved pain control with increased doses ■ Different psychological and physiological etiologies of tolerance exist and will influence the type of intervention

Step B: Address Serious Non-adherent Behaviors

General Strategy

- Address safety issues immediately and apply legal mandates as appropriate
- Document and refer suspected suicidal patients to behavioral health specialist
- Discontinue therapy in patients with evidence of diversion (selling or providing drugs to others) or dangerous behavior
- Refer as appropriate for emergency psychiatric evaluation
- Consider notifying law enforcement about suspected criminal behaviors; consult with counsel prior to doing so
- Follow documentation protocol of situation as advised by risk management and/or legal counsel

Types of Illegal or Criminal Behavior

- Active diversion
- Prescription forgery
- Alteration, theft, sales of prescriptions or use of someone else's prescription

Types of Dangerous Behavior

- Motor vehicle crash or arrest related to opioid or illicit drug or alcohol intoxication
- Intentional or unintentional overdose or suicide attempt
- Assaultive behaviors
- Aggressive, threatening or belligerent behavior in or out of the clinic

Step C: Address Minor Non-adherent Behaviors or Medication Misuse

General Strategy

- Educate patient
- Adjust clinical structure and behavioral interventions
- Revise treatment to address relatively minor behavioral problems

Treatment Agreement

- Consider adjustment of initial treatment agreement with emphasis upon specific adherence issues that have been identified. Adjustments include:
  - Review, discussion and restatement of the treatment plan
  - Revisions to opioid treatment agreement
  - Referral to a pain, SUD or behavioral health specialist
  - Administration of medications under supervision with the help of others
  - Change of medication, dose or amount dispensed
  - More frequent clinic contacts
  - Perioidic or random urine toxicology screens

Other Safety Measures

- Consider setting up a grievance procedure with the patient
- Consider involvement of family members or significant others to identify solutions to non-adherence and monitor future adherence when possible
- Encourage the patient to add more structure to their daily activities and living situation

Urine Drug Testing Table

If you suspect that the patient displays non-adherent behaviors or medication misuse, amend the treatment agreement to allow for routine urine drug testing.

Length of Time Drugs of Abuse Can Be Detected in Urine	
Drug	**Time**
Alcohol	7-12 h
Amphetamine	48 h
Methamphetamine	48 h
Bartituate	
Short-acting (e.g., pentobarbital)	24 h
Long-acting (e.g., phenobarbital)	3 wk
Benzodiazepine	
Short-acting (e.g., lorazepam)	3 d
Long-acting (e.g., diazepam)	30 d
Cocaine Metabolites	2-4 d
Marijuana	
Single use	3 d
Moderate use (4 times/wk)	5-7 d
Daily use	10-15 d
Long-term heavy smoker	> 30 d
Opioids	
Codeine	48 h
Heroin (morphine)	48 h
Hydromorphone	2-4 d
Methadone	3 d
Morphine	48-72 h
Oxycodone	2-4 d
Propoxyphene	6-48 h
Phencyclidine	8 d

Step D: Address Moderate Non-adherence

Structured Program

- Consider referral to a more structured program if the patient exhibits persistent or troublesome aberrant behavior (e.g., pharmacy pain management clinic, pain medicine clinic)

Addiction Specialist

- Consider referral to an addiction specialist if:
  - The non-adherent behaviors are associated with possible addiction
  - The patient presents with a history of substance abuse or co-occurring psychiatric condition

Behavioral Health Specialist

- Consider consultation with or referral to behavioral health specialist if:
  - Exacerbation of an underlying psychotic disorder emerges
  - Non-adherent behaviors appear due to changes in mood
  - Evidence of increased and poorly controlled anger

If you suspect addiction, you must refer the patient to specialists for further evaluation or treatment in accordance with local policies.

If such programs or specialists are not available, consider continuation of OT and monitor, screen, perform comprehensive behavioral assessment and address co-occurring conditions on a more frequent basis.

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Consult/Refer and Follow Up

Tab 6:

CONSULT/REFER AND FOLLOW UP

Step A:

Observe Patient Behavior

Step B:

Consider Consultation/Referral

Step C:

Follow Up as Necessary

Step A: Observe Patient Behavior

Distinguish Between Behaviors

- Distinguish and identify the difference between criminal activities and addictive behaviors
  - There are significantly different implications for the prescriber to consider
  - Address safety issues immediately and apply legal mandates as appropriate
  - Consult with your medico-legal expert if you suspect criminal conduct (see CPG p. 75)

Address Complications

- Address any complications, co-occurring conditions or other indications that require consultation or referral according to:
  - Needs of the patient
  - Nature of the problem
  - Impact on the mission if active duty

PREDICTORS OF POOR COMPLIANCE WITH OT

Patient has…
Prior poor or questionable adherence and motivation with the provider (weak therapeutic relationship)
Addiction/abuse behaviors are significant in severity or number
Pre-existing or concurrent other substance abuse/addiction
Unwillingness to comply with heightened compliance supervision measures
Chronic pain management that is already biopsychosocially maximized
Only mildly improved insight regarding addiction/abuse behaviors and their harm after education from the addiction specialist
Lack of motivation for changing addiction/abuse behaviors
An unsupportive recovery environment, to include active substance abuse by others in the home

Step B: Consider Consultation/Referral

Patient on OT should have one designated provider who is primarily responsible for overall medical care. This clinician may or may not provide OT, but should coordinate consulation and communicate between all clinicians involved in patient care. Document ALL of the patient's information from ALL clinicians involved in the patient's treatment.

Consider Addiction Specialist
(See next page for more information)

- Special attention should be given to those patients who display moderate- to high-risk behavior to misuse their medications and those whose living arrangements may create a risk for medication misuse or diversion
- Consider consultation with an addiction specialist when patients present with behaviors suggestive of opioid abuse or addiction to either opioids or other drugs. These include:
  - Rapidly escalating demands for dose increases Observed or reported intoxication or unexplained withdrawal symptoms
  - Frequent reports that opioid medication was lost, stolen or destroyed
  - Ingestion of opioids in ways other than prescribed (e.g., snorting, injecting)
  - Threat or harrassment to staff
  - Repeatedly seeking prescriptions from other providers or emergency departments
  - Alteration, theft, sales of prescriptions or use of someone else's prescription

Consider Pain Medicine Specialist

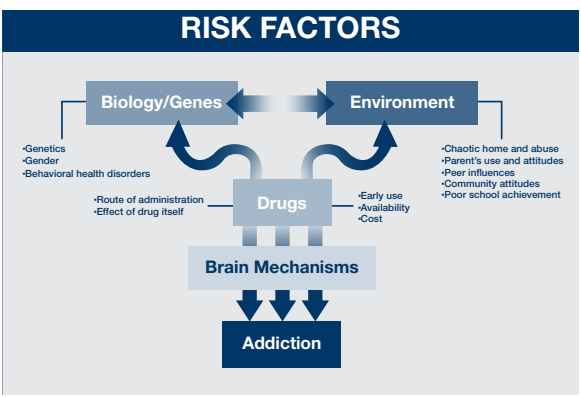
- Consider referral to a pain medicine specialist in the following situations:
  - Patient with complex pain or polytrauma
  - Patient with significant medical comorbidities that may negatively impact OT
  - Patient who is unable to tolerate increased pain or physical withdrawal symptoms that arise from opioid tapering when OT is discontinued
  - Patient with suspected opioid-induced hyperalgesia or opioid tolerance
  - Patient for whom high doses of medication provide no further improvement in function
  - Patient who requires management beyond the expertise of the primary provider

Consider Behavioral Health Provider

- When significant psychosocial, emotional, behavioral, cognitive or occupational health factors complicate chronic pain treatment, referral for interdisciplinary pain care involving behavioral health specialists is appropriate. If patient presents with suicidal ideation, refer to a behavioral health provider immediately. Consider referral to or consultation with a behavioral health provider in the following situations:
  - Exacerbation of an underlying psychotic disorder
  - Uncontrolled, severe psychotic disorder or those who are emotionally unstable
  - Demonstration of high-risk behaviors or verbalization suggestive of suicidal ideations
  - Psychosocial problems or co-occurring conditions that may benefit from case management
  - Adverse behavioral or cognitive effects of OT
  - Co-occurring trauma-related conditions (e.g., TBI, PTSD)
  - Expressed interest in alternative approaches
  - Current behavioral health provider's recommendation

Common Addictive Behavior Characteristics

This graphic illustrates the common risk factors that predict addiction. Vulnerability to addiction differs from person to person. When prescribing opioids, it is important for the provider to understand the risk factors surrounding the patient.



Step C: Follow Up as Necessary

Prompt documentation is essential and the medical record for each encounter should specifically address comfort, function, adverse effects and treatment plan adherence.

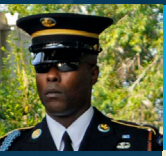
General Strategy

- Schedule follow-up visits at least every two to four weeks after ANY change in medication regime and at one to six months for maintenance
- Evaluate and document comfort, adverse reactions, functional status and aberrant behaviors at each visit
- Request a consult if needed
- Order lab studies and/or drug screens as needed

Assess

- Assess at each visit:
  - Comfort (degree of analgesia)
  - Opioid-related adverse effects
  - Functional status (physical and psychosocial)
  - Adherence to opioid treatment agreement and other aspects of treatment plan
  - Obtain laboratory studies (especially liver or kidney function screens) and/or order drug screens as indicated
  - Use of self-report instruments (diary, opioid log) may be helpful but should not be required
  - Dangerous and illegal behaviors*

*Illegal, dangerous and criminal behaviors have an impact beyond the patient and clinician and must be addressed at the time the action becomes apparent to the treatment team or provider. Behaviors that are illegal or that jeopardize the safety of the patient or society may require immediate consultation and/or referral to a specialist. In addition, prompt documentation is mandated and consideration of notifying law enforcement and consultation with your medico-legal expert is recommended.



Discontinue

Tab 7:

DISCONTINUE

Step A:

Indication to Discontinue

Step B:

Educate the Patient

Step C:

Taper and Follow Up

Step A: Indication to Discontinue

Make the Decision to Discontinue

- OT should be tapered off and discontinued if any of the following situations occur:
  - Goals of treatment are not ultimately met
  - The medication fails to show partial analgesia with incremental dose titration
  - Trials with different agents provide inadequate analgesia
  - There is other evidence that the pain may not be opioid responsive
  - Real or potential harms outweigh real or potential benefits
  - Patient requests to discontinue medication
- Evaluation of patient to include all co-occurring disorders and relevant factors should be completed prior to taper initiation
- Consider taper if pain level decreases in stable patients

Discuss the Option of Therapy

- Discuss non-opioid and non-pharmacologic alternatives
- Document and offer referral to addiction specialist for patients who demonstrate behaviors that suggest addiction to prescribed opioids or SUD
- Discuss pharmacotherapy options with all patients with opioid and/or alcohol dependence
- Stop opioid prescription immediately and educate patient about potential withdrawal if there are clear signs of unsafe or illegal behaviors

Step B: Educate the Patient

Resistance from the Patient

- If the patient does not agree with the decision to withdraw opioid therapy, be aware of possible unwanted behaviors from the patient
- Attempt to maintain contact with any patient who withdraws from treatment due to a disagreement. A grievance procedure can be presented either before or during ongoing therapy. The Joint Commission (TJC) has specific recommendations. The provider may alert the patient representative of the hospital in advance about possible treatment disagreements and other treatment providers about any controversy to coordinate providers' efforts
- Refer patients with co-occurring psychiatric health disorders to appropriate behavioral health providers. Identify and document any co-occuring disorders in patients with SUD, and refer to addiction specialist

Withdrawal Symptoms

- Provide clear written and verbal instructions to patients and caregivers to educate about the slow taper protocol, as well as the proper way to dispose of opioids
- Prepare the patient to discontinue opioids by tapering opioids gradually to minimize withdrawal symptoms
- Medically managed withdrawal is successful to the degree the patient:
  - Is physiologically stable
  - Avoids hazardous medical consequences of withdrawal
  - Experiences minimal discomfort
  - Reports being treated with respect for his or her dignity
  - Completes the tapering protocol (e.g., no longer requires medication for withdrawal symptom management)
  - Continues care for SUD

Step C: Taper and Follow Up

Protocol for Tapering
(See CPG for detailed guidelines)

- In general, the longer the person has been on opioids, the slower the taper should be
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids
- Taper by 20-50 percent per week for patients who are not addicted
- Rapid detoxification literature indicates that a patient needs 20 percent of the previous day's dose to prevent withdrawal symptoms
- Consider tapering opioids in any patients who have received regularly scheduled opioids at greater than the recommended starting doses for more than a few days
- Patients taking opioids on a non-daily, as-needed basis can typically have their medication discontinued without tapering
- Consider patient-specific factors when deciding whether the patient needs to taper and at what rate: risk of precipitating withdrawal, patient's level of anxiety about discontinuing opioids, duration of opioid therapy, medical and psychological comorbidities, and clinical need for rapid taper
- Patients with confirmed undetectable urine or blood opioid levels may be able to discontinue opioids without tapering
- Patients who present with acute withdrawal symptoms may be managed with symptomatic treatment and/or gradual tapering or, if indicated, referred to a medically supervised withdrawal (detoxification) program
- Patients who develop a true allergic hypersensitivity reaction to their opioid should have therapy discontinued immediately
- Consider using adjuvant agents such as antidepressants to manage irritability and sleep disturbance, or antiepileptics for neuropathic pain
- Clonidine 0.1 mg twice or three times daily may be used to control many withdrawal symptoms if there are no contraindications. Supplemental medications will often be required as clonidine will not address all withdrawal symptoms (e.g., muscle and joint aches, nausea, diarrhea, anxiety)

Follow Up

- Do not abandon a patient under any circumstances
- Maintain contact with any patient who withdraws from treatment due to a disagreement. The provider may alert the patient representative of the hospital in advance about possible treatment disagreements and other treatment providers about any controversy to coordinate providers' efforts
- Refer patients with co-occurring psychiatric health disorders to appropriate behavioral health providers
- Refer patients with known SUD to addiction specialist

Suggested tapers for...

1. Methadone
   - Decrease dose by 20-50 percent/day until you reach 30 mg/day
   - Then decrease by 5 mg/day every three to five days to 10 mg/day
   - Then decrease by 2.5 mg/day every three to five days
2. Morphine SR/CR
   - Decrease dose by 20-50 percent/day until you reach 45 mg/day
   - Then decrease by 15 mg/day every two to five days
3. Oxycodone CR
   - Decrease dose by 20-50 percent/day until you reach 30 mg/day
   - Then decrease by 10 mg/day every two to five days

For specific treatment recommendations to address any adverse effects or treatment complications, refer to CPG.

Medication Tables

Tab 8:

MEDICATION TABLES

Opioid Medication Table

The opioid medications described in this table are divided into the following sections: long-acting, combination and short-acting medications. Within each section, the medications are alphabetized. The long-acting and short-acting medications are listed together based on their duration of action. The combination opioid medications can be combined with other medications or given alone. Opioids should be used cautiously with elderly or debilitated patients. Additionally, use caution in patients with hepatic or renal dysfunction.

SHORT-ACTING OPIOID MEDICATIONS

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Hydromorphone IR (Dilaudid)	2 mg every four to six hours.	Individually titrate as needed and tolerated; doses ≥ 4 mg every four to six hours may be necessary.	Yes

Contraindications: include hypersensitivity, patients with respiratory depression in the absence of resuscitative equipment, status asthmaticus, obstetrical analgesia

Additional Information:

- May be given as a tablet, suppository or oral liquid
- Use with extreme caution in patients with chronic obstructive pulmonary disease or cor pulmonale, a substantially decreased respiratory reserve, hypoxia, hypercapnia or preexisting respiratory depression

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Morphine IR	10 to 30 mg every four hours.	Individually titrate as needed and tolerated.	No

Contraindications: include hypersensitivity, respiratory depression in the absence of resuscitative equipment, acute or severe bronchial asthma or hypercarbia, known or suspected paralytic ileus

Additional Information:

- May be given as a tablet, oral solution or suppository
- Use with extreme caution and with lower doses in the elderly or debilitated patients
- Use carefully in hepatic dysfunction, reduce the dose or extend the dosing interval by 1.5 to 2 times
- Reduce the dose in renal impairment and avoid use in severe impairment
- Morphine has active metabolites (M3G and M6G) which may accumulate in renal impairment and contribute to toxic effects

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Oxymorphone IR (Opana)	10 to 20 mg every four to six hours (may start at 5 mg to improve tolerability).	Individually titrate as needed and tolerated.	No

Contraindications: include hypersensitivity to oxymorphone or morphine analogs such as codeine, respiratory depression (except in monitored settings and in the presence of resuscitative equipment), acute or severe bronchial asthma or hypercarbia, known or suspected paralytic ileus, patients with moderate and severe hepatic impairment

Additional Information:

- Must be taken on an empty stomach at least one hour before or two hours after a meal. Food has been shown to increase peak levels by 38 percent
- Renal dysfunction: start at lower doses and titrate slowly

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Tapentadol IR (Nucynta)	50 mg every four to six hours.	Subsequent dose is 50, 75 or 100 mg every four to six hours, adjusted to analgesia and tolerability.	No

Contraindications: include impaired pulmonary function (significant respiratory depression, acute or severe bronchial asthma, hypercapnia in unmonitored settings or absence of resuscitative equipment), known or suspected paralytic ileus, use within 14 days of monoamine oxidase inhibitors (MAOIs)

Additional Information:

- Inhibits reuptake of serotonin and norepinephrine; potentially life-threatening serotonin syndrome could result with concomitant use of other serotonergic agents and drugs that impair metabolism of serotonin (e.g., MAOIs)
- Consider starting at the lower end of recommended doses in the elderly
- Do not use in severe hepatic dysfunction or severe renal dysfunction
- Use only under careful medical supervision at lowest effective dose
- If used in combination with other CNS depressants, consider dose reduction of one or both agents
- Doses of tapentadol should NOT be considered equianalgesic to the doses of pure agonists. Equianalgesic doses have not been established for conversions between tapentadol and pure opioid agonists
- Withdrawal symptoms may occur if discontinued abruptly
- Patients should be cautioned about the risk of impaired mental and/or physical abilities required for performing potentially hazardous tasks such as driving a car or operating machinery

See CPG for Combination Therapies

LONG-ACTING OPIOID MEDICATIONS

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Fentanyl Transdermal Patch (Duragesic)	New dosing became available after the CPG was published -12 mcg/hour transdermal every 72 hours.	Increments should be based on supplemental opioid doses, using a ratio of 12 mcg/hour transdermal fentanyl for every 45 mg/24 hour of supplemental oral morphine equivalent. Make increment changes at least three days after initial dose then not more often than every six days thereafter as necessary.	Yes

Fentanyl Transdermal Patch (Duragesic) (Cont.)

Contraindications: include hypersensitivity, patients who are not opioid tolerant, management of acute pain or for short-term treatment, management of post-op pain, mild pain, or intermittent pain, significant respiratory depression (especially in unmonitored settings), acute or severe bronchial asthma, known or suspected paralytic ileus

Additional Information:

- Consider in patients with persistent, moderate to severe pain who cannot take oral long-acting morphine and methadone
- Using the fentanyl patch entails special safety considerations. All prescribers should be thoroughly familiar with the product's prescribing information
- Patients must receive a copy of the medication guide
- In order to avoid any confusion, always write fentanyl in mcg/hr
- Should not be used in patients particularly susceptible to intracranial effects of CO2 retention (increased intracranial pressure, impaired consciousness, coma)
- Fentanyl patches should ONLY be used in patients who are already receiving opioid therapy, are opioid-tolerant and require a daily dose at least equivalent to fentanyl 25 mcg/hour
- Rotate to a different opioid either long-acting morphine or methadone in order to taper patient off of the medication. Alternately, taper down to 12 mcg/hour patches and then give a brief supply of oral short acting opioids to complete the taper
- Avoid application of external heat sources (e.g., heating pads, electric blankets, heat lamps, saunas, hot tubs, hot baths, sunbathing or heated water beds) to the application site while the patch is worn as heat may increase the release of fentanyl
- Do not cut or alter the patch which could result in an over dosage
- If leakage of the fentanyl gel occurs, wash any skin that has come in contact with the gel with copious amounts of water only. Do not use soap or alcohol

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Methadone (Dolophine, Methadose)	2.5 mg every eight to 12 hours.	Start low and go slow. May increase every five to seven days by 2.5 mg every 12 hours.	Yes

Contraindications: include hypersensitivity, any situation where opioids are contraindicated, such as patients with respiratory depression (in absence of resuscitative equipment or in unmonitored situations) and patients with acute bronchial asthma or hypercarbia, known or suspected paralytic ileus

Additional Information:

- Obtain ECG prior to the start of therapy, once the dose is stabilized and annually thereafter
- Should not be used for as-needed supplemental opioid therapy
- Delayed analgesia or toxicity may occur because of drug accumulation after repeated doses (e.g. on days two to five). If the patient has excessive sedation during this timeframe, consider temporarily holding dose(s), lowering the dose and/or slowing the titration rate
- Prescribers of methadone should be thoroughly familiar with its complex pharmacokinetic and pharmacodynamic properties or consult a clinician with experience in dosing methadone
- The only long-acting opioid available as an oral solution
- Methadone is FDA approved for the detoxification treatment of opioid addiction. If used in detoxification, then it must be used as part of an FDA approved program
- May prolong QTc intervals on ECG, risk of torsade de pointes
- Inform patient of arrhythmia risk and ask patient about heart disease, arrhythmia and syncope family history
- Discontinue or taper the methadone dose and consider an alternative therapy if the QTc > 500 ms
- Contact the local pharmacy for drug to drug interactions
- Extended plasma half-life may be longer than the analgesic duration
- Incomplete cross-tolerance with other opioids makes dosing during conversion from other opioids to methadone complex; a high degree of "opioid tolerance" does not eliminate the possibility of methadone overdose

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Morphine Controlled Release (CR), Sustained Release (SR), (MS Contin, Oramorph SR), Extended Release (ER) (Avinza, Kadian)	15 mg every eight to 12 hours (CR/SR). 30 mg every 24 hours (ER).	Total daily increments of < 30-40 mg/day may be made every two days.	Yes

Contraindications: include hypersensitivity, respiratory depression in the absence of resuscitative equipment, acute or severe bronchial asthma or hypercarbia, known or suspected paralytic ileus

Additional Information:

- Controlled-release tablets should be swallowed whole, not broken, chewed or crushed. For patients who have difficulty swallowing, SR and ER capsules may be opened and the pellets may be sprinkled onto a small amount of soft food (e.g., apple sauce). The mixture should be taken within 30 minutes of sprinkling. The pellets must not be chewed or crushed, and the mouth should be rinsed to ensure that all pellets have been swallowed
- MS Contin: 8-12 hour extended release capsules for use in the opioid-tolerant patient only
- Use with extreme caution and with lower doses in the elderly or debilitated patients
- Use carefully in hepatic dysfunction, reduce the dose or extend the dosing interval
- Reduce the dose in renal impairment and avoid use in severe renal impairment
- Due to fumaric acid content in Avinza, doses above 1600 mg may result in serious renal toxicity
- Morphine has active metabolites (M3G and M6G) which may accumulate in renal impairment and contribute to toxic effects
- Avinza: maximum of 1600 mg per day
- Avinza: 24-hour extended release capsules for once a day therapy
- Kadian: 12-24 hour extended release capsules for use in the opioid-tolerant patient only

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Oxycodone CR (Oxycontin)	10 mg every 12 hours.	May increase to 20 mg every 12 hours after one or two days. Thereafter, the total daily dose may be increased by 25-50 percent of the current dose every one or two days.	Yes

Contraindications: include hypersensitivity, any situation where opioids are contraindicated, such as patients with significant respiratory depression (in absence of resuscitative equipment or unmonitored situations) and patients with acute bronchial asthma or hypercarbia, known or suspected paralytic ileus

Additional Information:

- Recommended for patients who experience intolerable, unmanageable adverse effects to long-acting morphine and to methadone
- Advise patients that controlled release tablets should be swallowed whole, not broken, chewed or crushed
- Use one-third to one-half the initial dose in the elderly, debilitated or hepatic dysfunction patients
- Dose conservatively in renal dysfunction patients

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Oxymorphone ER (Opana)	5 mg every 12 hours.	May increase by 5-10 mg every 12 hours every three to seven days.	Yes

Contraindications: include hypersensitivity to oxymorphone or morphine analogs such as codeine, respiratory depression (except in monitored settings and in the presence of resuscitative equipment), acute or severe bronchial asthma or hypercarbia, known or suspected paralytic ileus, patients with moderate and severe hepatic impairment

Additional Information:

- Must be taken on an empty stomach at least one hour before or two hours after a meal. Food has been shown to increase peak levels of oxymorphone ER by 50 percent
- Use low initial dose and titrate slowly in the elderly, debilitated, hepatic and renal dysfunction patient

Drug	Initial Dose	Dose Titration	Black Box Warning – TAB 9
Tramadol ER (Ultram)	100 mg once daily. If converting from tramadol IR, start at 24 hour dosage equivalent rounded down to closest 100 mg increment.	Increase by 100 mg every five days based on analgesia and tolerability.	No

Contraindications: include hypersensitivity to tramadol and any situation where opioids are contraindicated

Additional Information:

- Maximum dose: 300 mg/day
- Must be swallowed whole and must not be chewed, crushed or split
- Should not be used in severe hepatic impairment or CrCL < 30 ml/min
- Use caution in the elderly > 65 years of age and start at the low end of the range
- FDA warnings for the risk of suicide for patients who are addiction-prone, taking tranquilizers or antidepressant drugs. FDA warnings also exist for the risk of overdosage
- Dose carefully or use another agent in patients on norepinephrine/serotonergic agents

Black Box Warnings and Resources

Tab 9:

BLACK BOX WARNINGS AND RESOURCES

Opioid Medications – Black Box Warnings	
Hydromorphone IR (Diaudid)	■ Injectable Hydromorphone available in 1-, 2-, 4- and 10-mg/mL concentration; high-potency 10 mg/mL concentration ONLY for use in opioid-tolerant patients ■ High potential for abuse and risk of respiratory depression
Fentanyl Transmucosal (Onsolis, Fentora, Actiq)	■ Abuse liability similar to other opioid analgesics ■ Indicated only for management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for underlying persistent cancer pain ■ Must not be used in opioid non-tolerant patients ■ Intended for use only by oncologists and pain specialists knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain ■ Contains medicine in an amount that can be fatal to a child. Keep out of reach of children and discard opened units properly ■ Concomitant use with strong and moderate CYP 3A4 inhibitors may increase plasma concentrations and cause potentially fatal respiratory depression
Fentanyl Transdermal Patch (Duragesic)	■ High content of fentanyl in the patches may be a particular target for abuse and diversion ■ Indicated for management of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time and cannot be managed by other means. Use only in patients who are already receiving opioid therapy, have demonstrated opioid tolerance and require a total daily dose at least equivalent to fentanyl transdermal system 25 mcg/hour. Use in non-opioid tolerant patients may lead to fatal respiratory depression ■ Peak fentanyl levels between 24 and 72 hours; serious or life-threatening hypoventilation may occur, even in opioid-tolerant patients, during the initial application period ■ Overestimating dose when converting patients from another opioid medication can result in fatal overdose with the first dose ■ Patients thought to have had a serious adverse event, including overdose, require monitoring and treatment for at least 24 hours ■ Administer to children only if opioid tolerant and two years of age or older ■ Concomitant use with CYP 3A4 inhibitors may increase plasma concentrations, increase or prolong adverse drug effects and cause potentially fatal respiratory depression ■ Using damaged or cut fentanyl transdermal patches can lead to rapid release of fentanyl and absorption of a potentially fatal dose

Fentanyl Transdermal Patch (Duragesic) (Cont.)	■ Potential for temperature-dependent increases in fentanyl release, resulting in possible overdose and death. Avoid exposing application site and surrounding area to direct heat sources; monitor patients with fever or increased core body temperature
Methadone (Dolophine, Methadose)	■ Deaths reported during initiation of methadone for opioid dependence; some cases appear related to too-rapid titration without appreciation for accumulation of methadone over time. Understanding methadone pharmacokinetics and vigilance during initiation and titration is critical. Strongly caution patients against self-medicating with CNS depressants during initiation of methadone ■ Peak respiratory effects typically occur later and persist longer than peak analgesic effects, particularly in the early dosing period; can contribute to iatrogenic overdose ■ Methadone inhibits cardiac potassium channels and prolongs the QTc interval. QTc interval prolongation and serious arrhythmia (torsades de pointes) observed; more common in patients being treated for pain with large, multiple daily doses ■ Federal law governs distribution and use for treatment of opioid addiction ■ Methadone dispersible tablets are for oral administration only
Morphine Controlled Release (CR), Sustained Release (SR), (MS Contin, Oramorph SR), Extended Release (ER) (Avinza, Kadian)	■ 8-12 hour extended release tablets – Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time – Swallow whole; taking broken, chewed, dissolved or crushed tablets leads to rapid release and absorption of a potentially fatal dose – MS Contin (brand name) – 100 mg and 200 mg tablets for use in opioid-tolerant patients only ■ 24-hour extended release capsules – Indicated for once-daily administration for relief of moderate to severe pain requiring around-the-clock opioid therapy for an extended period of time – Swallow whole or sprinkle on applesauce; do not chew, crush or dissolve due to risk of rapid release and absorption of a potentially fatal dose – Avinza (brand name) – Patients must not consume alcoholic beverages or medications containing alcohol; may result in rapid release and absorption of a potentially fatal dose of morphine – Kadian (brand name) - 100 mg and 200 mg capsules for use in opioid-tolerant patients only

Oxycodone CR (Oxycontin)	■ Abuse liability similar to morphine ■ Indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time; not intended for use as an as-needed analgesic ■ Controlled release of 80 and 160 mg tablets for use in opioid-tolerant patients must be swallowed whole. If broken, chewed or crushed they become rapid relase and may be potentially fatal
Oxymorphone ER (Opana)	■ Abuse liability similar to other opioid analgesics ■ Indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time; NOT intended for use as an as-needed analgesic. Swallow whole; taking broken, chewed, dissolved or crushed tablets may lead to rapid release and absorption of a potentially fatal dose of oxymorphone ■ Patients must not consume alcoholic beverages or medications containing alcohol; may result in increased plasma levels and a potentially fatal overdose
Buprenorphine Transdermal Patch (Butrans) - not included in the VA/DoD 2010 Opioid Therapy for Chronic Pain CPG	■ Proper patient selection: The transdermal formulation of buprenorphine is indicated for the management of moderate to severe chronic pain in patients requiring a continuous, around-the-clock opioid analgesic for an extended period of time ■ Buprenorphine is a mu opioid partial agonist and a schedule III controlled substance. Buprenorphine can be abused in a manner similar to other opioid agonists, legal or illicit. Consider the abuse potential when prescribing or dispensing buprenorphine in situations in which the health care provider or pharmacist is concerned about an increased risk of misuse, abuse or diversion ■ Persons at increased risk for opioid abuse include those with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). Assess patients for their clinical risks for opioid abuse or addiction prior to being prescribed opioids. Routinely monitor all patients receiving opioids for signs of misuse, abuse and addiction ■ Do not exceed a dose of one buprenorphine system 20 mcg/h because of the risk of QTc interval prolongation ■ Avoid exposing the buprenorpine system application site and surrounding area to direct external heat sources. Temperature-dependent increases in buprenorphine release from the system may result in overdose and death

Hydromorphone ER (Exalgo ER) - not included in the VA/DoD 2010 Opioid Therapy for Chronic Pain CPG	■ Hydromorphone ER has an abuse potential similar to other opioid agonists and this should be considered when prescribing, dispensing or administering the medication. This medication should be used in opioid-tolerant patients only, as use in non-opioid tolerant patients may lead to fatal respiratory depression. Accidental consumption may lead to fatal overdose, especially in children ■ Do not use for the management of post-operative or acute pain or on an as-needed basis. Breaking, chewing, crushing, dissolving or administering the medication in any form other than as a whole tablet may lead to a rapid, potentially fatal drug or dose
Tapentadol ER (Nucynta ER) - not included in the VA/DoD 2010 Opioid Therapy for Chronic Pain CPG	■ Nucynta ER (Tapentadol ER) contains tapentadol, a mu-opioid agonist and a schedule II controlled substance with an abuse liability similar to other opioid analgesics ■ Tapentadol ER can be abused in a manner similar to other opioid agonists, legal or illicit. These risks should be considered when prescribing or dispensing this drug in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse or diversion ■ Schedule II opioid substances, which include hydromorphone, morphine, oxycodone, fentanyl, oxymorphone and methadone have the highest potential for abuse and risk of fatal overdose due to respiratory depression ■ Nucynta ER is an extended release formulation of tapentadol indicated for the management of moderate to severe chronic pain in adults when a continuous, around-the-clock opioid analgesic is needed for an extended period of time ■ Tapentadol ER is not intended for use as an as-needed analgesic ■ Tapentadol ER is not intended for the management of acute or postoperative pain ■ Tapentadol ER tablets are to be swallowed whole and are not to be split, broken, chewed, dissolved or crushed. Taking split, broken, chewed, dissolved or crushed tapentadol ER tablets could lead to rapid release and absorption of a potentially fatal dose of the drug. ■ Patients must not consume alcoholic beverages, prescription or non-prescription medications containing alcohol. Co-ingestion of alcohol with this product may result in a potentially fatal overdose of tapentadol.

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