Managing Chronic Pain
with Opioids in Primary Care

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Disclaimer
The information provided is not medical advice provided by a physician and is not a substitute for such advice. This guide contains recommendations compiled by clinicians in the field to assist others caring for chronic pain patients. We define chronic pain as persistent pain that has lasted for more than 3 months. Clinicians should use their best judgment on how to incorporate information from this guide into their daily practice. If users of the guide have any questions or concerns regarding usage, they should seek the advice of a licensed physician.

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Preface

Optimal treatment of patients with chronic, moderate to severe pain presents a number of challenges for physicians and other healthcare providers. It is not always clear when opioid pain medication is most appropriate. If opioids are indicated, which medications are optimal for a specific pain problem, what should be done if the medication is not well tolerated, and how long should the patient be treated? Clinicians may be reluctant to prescribe opioid pain medications because they are increasingly concerned about the possibility that they may be causing opioid addiction in some individuals, or that state or federal monitoring agencies may accuse them of inappropriate prescribing.

The purpose of this Pocket Guide is to provide a user-friendly, logically organized, and comprehensive guide to the evaluation and treatment of patients who might benefit from opioid analgesia. The goal is to provide easily accessible information to practicing clinicians that addresses their concerns about prescribing opioids, while at the same time providing for the safe and effective treatment of their patients with chronic, moderate to severe pain. Evidence-based information about assessing the risk of opioid abuse, how to prevent or manage side effects of opioids, when and how to discontinue opioid treatment, and practical tips on how to organize your office to support safe opioid prescribing and limit the likelihood of opioid abuse are all included.

The first part of the Guide provides general information about the assessment and long-term management of chronic pain patients with opioids. This is followed by a series of appendices that contain detailed “how-to” information, as well as examples of commonly used tools especially useful for determining the risk that a particular patient might misuse his or her opioid prescription. The Guide has been specifically designed to be small enough to carry with you while seeing patients in the clinic, and it includes tabs for easy access to information regarding specific opioid-related questions. We hope you find this reference useful.

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Stepwise Guide to Safely Managing Chronic Pain With Opioids

Step 1: Prepare Your Practice

Step 2: Assess and Triage Patient

Step 3: Initiate Opioid Trial

Step 4: Manage Opioid Therapy

- Rotate Opioid
- Reassess Patient
- Continue Opioid Therapy

Step 5: Employ Exit Strategy

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Note: For easy reference, the tabs on this Pocket Guide follow these steps for the management of chronic pain with opioids.
Preparing Your Practice

There are a variety of steps you will want to consider to prepare your practice with regard to the multiple regulatory issues and responsibilities regarding prescribing an opioid for pain treatment.

- Go to your state medical board’s Web site, and review state laws regarding opioid treatment.
  - A summary of state regulations is available at www.painpolicy.wisc.edu/matrix.html
- Know the status of your state’s prescription monitoring program (PMP).
- Understand your legal responsibility.
  - Review US Department of Justice Drug Enforcement Agency’s overview of the Controlled Substances Act (CSA).
    - www.deadiversion.usdoj.gov/schedules/schedules.htm
  - Familiarize yourself with legal/regulatory compliance issues.
    - For more information, go to www.legalsideofpain.com and www.painpolicy.wisc.edu
- Familiarize yourself with common characteristics of patients at risk for opioid abuse (see Appendix 5).
- Educate your office staff (see Appendix 1).
- Develop and implement compliance programs for
  - Pain management billing and coding
  - The use of controlled substances to treat pain
  - The office-based treatment of opioid addiction
Initial Patient Assessment for Opioid Therapy

The guidelines provided below focus on elements of the patient assessment specifically relevant to long-term opioid therapy. The main goals of the patient assessment for opioid therapy are as follows:

• To determine whether opioids are the most appropriate treatment for the patient, or whether treatments with different risk/benefit ratios should be considered
• To categorize (triage) the patient into levels of risk for substance abuse (see page 11)
• To inform an assessment of the risk-benefit ratio of long-term opioid therapy

As with every other patient assessment in medicine, essential features are as follows (see Appendix 6 for details):

• Chief complaint
• History of present illness—pain history
  – Pain medication history
• Past history, including psychiatric and substance abuse histories
• Social history
• Family history
• Physical examination
  – Features relevant to pain and to substance abuse
• Additional information
  – Urine medication monitoring
  – Blood tests
  – Screening tests for risk of substance abuse
  – Prescription monitoring report
  – Outside medical records

Note: It is assumed that an appropriate evaluation for the underlying pain complaint is conducted with attention to the underlying diagnosis and any primary treatment (eg, cancer or infection).
Assessing Risk

The clinician can assess risk of abuse and addiction by observing the patient’s behavior and eliciting information during the initial evaluation and subsequent visits.

• Appendix 5 lists some behaviors that have been associated with addiction.
• Assessing risk is not an exact science:
  – When in doubt, get a consultation from a pain or addiction specialist, or refer the patient.

Screener and Opioid Assessment for Patients With Pain (SOAPP)

• SOAPP is a simple tool that clinicians can use to assess risk (see Appendix 7). The SOAPP is not intended to rule out opioid therapy as a possible treatment option for treating chronic pain. Rather, the SOAPP score, along with other clinical findings, can help the provider make a risk benefit assessment with regard to the use of opioid therapy. If opioid therapy is determined to be an appropriate treatment option, the SOAPP can help the provider determine the level of monitoring that may be necessary to safely prescribe long-term opioid therapy for a given patient.
• The 5-item SOAPP
  – Identifies risk level of patients for documentation and treatment planning
  – Is not intended to rule out patients for opioid therapy
  – Is part of a multifaceted approach to risk assessment
• Please see www.painedu.org/soap.asp for more information about SOAPP, to view the tutorial, or to download other versions.
# Triage Guide

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

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Characteristics</th>
<th>Management</th>
</tr>
</thead>
</table>
| **Low**    | • No history of substance abuse; minimal if any risk factors* | • Can be managed by primary care physician (PCP)  
• If aberrant behaviors are observed, consider increasing risk category |
| **Medium** | • History of substance abuse (not prescription opioid abuse); significant risk factors*  
• Patient previously assigned to low-risk category exhibits aberrant behaviors† | • PCP comanages with addiction and/or pain specialists  
• If aberrant behaviors are observed or persist, consider assigning to high-risk category |
| **High**   | • Active substance abuse problem; history of prescription opioid abuse  
• Patient previously assigned to medium-risk category exhibits aberrant behaviors | • Opioids may not be appropriate in the primary care setting  
• Refer patient to specialists in management of patients with comorbid pain and addictive disorders  
• Continue to manage patient’s medical care and monitor specialized care |

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

†See Appendicies 5 and 14 for lists of aberrant behaviors.
Opioid Trial Initiation Checklist

- Physicians:
  - Always consider opioid therapy to be a trial.
  - Choose opioids (see Appendix 13).

- Office staff:
  - Ensure patient’s chart includes
    - Completed Patient Medication Agreement (see Appendix 18)
    - Medication Flow Chart (see Appendix 2)
    - Printed Patient Education Brochure (see Appendix 17)

Patient Medication Agreements

- A patient medication agreement (also called a “contract”) or “informed consent” establishes clear expectations between physician and patient and specifies
  - Purpose of opioid therapy
  - Side effects
  - Treatment goals
  - Physician’s role in responsible opioid prescribing
  - Patient’s role in responsible opioid use

- Patient should review and sign the medication agreement after the initial assessment and if possible before an opioid trial is initiated.

- See Appendix 18 for a sample Patient Medication Agreement.

Key Components of a Patient Medication Agreement

- Opioid prescriptions are provided by only one PCP.
- Patients agree not to ask for opioid medications from any other doctor without the knowledge and assent of the PCP.
- Patients agree to keep all scheduled medical appointments.
- Patients agree to provide urine samples for drug screens.
- No prescriptions will be refilled early.
- No prescriptions will be refilled if lost, destroyed, or if medication has been stolen.
- Prescription refills will be authorized only during regular office hours.
- Patients agree to comply fully with all aspects of the treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended.
Patient Education

When initiating opioid therapy, clinicians should always carefully describe the rationale for the use of these medications, including the potential side effects and how to minimize them. Patients frequently have concerns about becoming addicted to the medication, or being perceived by friends or family as being an addict. For these and a number of other reasons, compliance with opioid treatment will likely be improved when clinicians spend the time to address patient concerns.

• Appendix 17 contains an educational brochure that may be copied and given to patients.
• Also consider directing patients to specific Web sites providing quality information in readable formats or frequently-asked-questions (FAQ) sections.

Choosing Opioids: Long-Acting and Short-Acting Preparations

• Depending on their pain profile, past experience, and abuse risk, some patients with chronic pain are best treated with
  – A long-acting opioid on a fixed-dose schedule for background pain and short-acting opioid for breakthrough pain
  – A long-acting opioid only
  – A short-acting opioid only
**Long-Acting Opioids**

- Slower onset of action (30-90 min)
- Relatively long duration (4-72 hours)
- Used on a round-the-clock basis for patients with constant background pain
- Long-acting by virtue of
  - Intrinsic pharmacokinetic properties
    - Methadone
    - Levorphanol
  - Incorporation into a slow-release delivery system
    - Controlled-release morphine
    - Controlled-release oxycodone
    - Controlled-release oxymorphone
    - Controlled-release tramadol
    - Transdermal fentanyl

**Short-Acting Opioids**

- Fast onset of action (10-60 min)
- Short duration of action (2-4 hours)
- Used for patients with intermittent pain or breakthrough episodes that are superimposed on constant background pain
  - Codeine
  - Hydromorphone
  - Oxymorphone
  - Tramadol
  - Hydrocodone
  - Oxycodone
  - Meperidine
  - Fentanyl (available for transmucosal use as a lollipop or fast-dissolving buccal tablet)

**Combination Products**

- Combine an opioid with a nonopioid analgesic (acetaminophen or a non-steroidal anti-inflammatory drug [NSAID])
  - Used for patients who do not require dose escalation beyond the limits of the nonopioid component
  - Combining different products generally gives better results than using either product alone
Selected Combination Drugs

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Combined With Acetaminophen</th>
<th>Combined With Ibuprofen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Tylenol with codeine N3®</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tylenol with codeine N4®</td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Hydrocet®</td>
<td>Vicoprofen®</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Endocet®</td>
<td>Combunox®</td>
</tr>
<tr>
<td></td>
<td>Percocet®</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percodan®</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roxicet®</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tylox®</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Combunox®</td>
<td></td>
</tr>
</tbody>
</table>

Recommended Starting Doses of Opioids

- Caution should be used in initiating opioids in patients who are not currently taking opioids.
- Respiratory depression can occur.
- For opioid-naïve patients, start with low doses of opioid and titrate up until pain relief is obtained without unacceptable toxicity.
- See Appendix 13 for dosing recommendations by medication.
Follow-up Checklist

• Use the Follow-up Visit Form to record information (see Appendix 14).
• Review medication flow chart; take pill counts.
  – Medication flow charts can identify early refills.
  – Pill counts can help identify whether patients are using their medications inappropriately.
• Perform a physical examination.
  – Evaluate the location and aggravating physical characteristics of the pain; determine if there has been a change since last visit.
  – Conduct mental health assessment at least annually (see Appendix 8).
• Conduct urine medication monitoring (see Appendix 10) or other toxicology screens, and other relevant lab tests.
  – Conduct endocrine lab tests annually (see Appendix 10).
• Determine if brief intervention is needed for possible substance abuse (see Appendix 11).
• Determine the action plan:*
  □ Continue present opioid regimen
    Adjust regimen as follows:
    □ Add/adjust concomitant therapy __________________________
    □ Add/adjust nonpharmacologic therapy ______________________
    □ Adjust present opioid _________________________________
    □ Rotate opioid _______________________________________
    □ Exit strategy: Taper patient off opioid regimen
    □ Other: ____________________________________________

*Adapted from Pain Assessment and Documentation Tool (PADT) provided by Janssen Pharmaceutica Products, LP.
## Preventing and Managing Side Effects

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Prevention</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>For high-risk (e.g., Alzheimer) patients maximize nonopioid regimen</td>
<td>Lower dose; switch opioids; low-dose neuroleptics if necessary</td>
</tr>
<tr>
<td>Constipation</td>
<td>Stool softeners; bowel stimulants; nonpharmacologic measures</td>
<td>Use common measures to treat constipation or switch opioids</td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td>Antivertiginous agents (e.g., scopolamine); lower dose (if possible); add co-analgesics</td>
</tr>
<tr>
<td>Edema and sweating</td>
<td></td>
<td>Switch opioids</td>
</tr>
<tr>
<td>Endocrine dysfunction/ reduced libido/ hypogonadism</td>
<td>Assess endocrine status at baseline and at least annually thereafter</td>
<td>Consider opioid rotation; consider strategies that allow opioid dose reduction; testosterone supplementation if hypogonadism is diagnosed; consider consultation with an endocrinologist; monitor prostate specific antigen (PSA) in males on testosterone supplementation</td>
</tr>
<tr>
<td>Hives</td>
<td>If patient has history, use opioid in different chemical group or family</td>
<td>Switch opioids; symptomatic treatment</td>
</tr>
<tr>
<td>Myoclonus</td>
<td></td>
<td>Switch opioids; to suppress myoclonus, consider low doses of baclofen, clonazepam, or gabapentin</td>
</tr>
<tr>
<td>Nausea</td>
<td>Coprescribe anti-emetics with each dose if patient has history of opioid-induced nausea/vomiting</td>
<td>Switch opioids; anti-emetics</td>
</tr>
<tr>
<td>Side Effect</td>
<td>Prevention</td>
<td>Treatment</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pruritus</td>
<td></td>
<td>Switch opioids; antihistamines</td>
</tr>
<tr>
<td>Rash</td>
<td>If patient has history, use opioid in different chemical group or family</td>
<td>Switch opioids; symptomatic treatment</td>
</tr>
<tr>
<td>Respiratory</td>
<td>“Start low, go slow.” Start with low doses of opioid and titrate to effect;</td>
<td>Close observation, supportive measures (airway, breathing, and circulation, or “ABC”); naloxone for overdose with respiratory or hemodynamic compromise</td>
</tr>
<tr>
<td>depression</td>
<td>monitor patient closely</td>
<td></td>
</tr>
<tr>
<td>Sedation</td>
<td>“Start low, go slow.” Start with low doses of opioid and titrate to effect;</td>
<td>Lower dose (if possible); add co-analgesics; add stimulants</td>
</tr>
<tr>
<td></td>
<td>monitor patient closely</td>
<td></td>
</tr>
<tr>
<td>Urinary retention</td>
<td></td>
<td>Switch opioids; lower dose (if possible)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Coprescribe anti-emetics with each regimen if patient has history</td>
<td>Switch opioids; anti-emetics such as prochlorperazine or ondansetron</td>
</tr>
</tbody>
</table>

Note: These symptoms even in patients on opioids may be due to other causes; a diagnostic evaluation is recommended.

Opioid Rotation

Clinical Reasons for Changing Opioids

Patients have been shown to respond to opioids differently based on a number of different variables, including genetic predisposition. This provides a rationale to switch (rotate) to a different opioid in the event that patient response does not yield successful management of the painful condition. In some cases, rotation may be necessary more than one time, or even a number of times to find the right opioid. Below are some reasons to support the strategy of opioid rotation.

Lack of Efficacy

- Development of opioid analgesic tolerance
- Patient has a poor response to first-line opioid
- Inability to tolerate effective dose
- Dose required to produce analgesia exceeds maximum daily dose recommendations

Development of Intolerable Side Effects

- Gastrointestinal (eg, constipation, nausea, vomiting)
- CNS (eg, sedation, somnolence, dysphoria, hallucinations, myoclonus)
- Vascular (eg, orthostatic hypotension)

Change in Patient Status

- Inability to swallow
- Poor peripheral vascular status/poor absorption of transdermal medications
- Patient is NPO
- Requirement of high-dose opioids that cannot be practically administered by oral, rectal, or transdermal routes

Practical Considerations

- Availability in local pharmacies
- Cost
- Amount of opioid needed
- Route of administration
- Patient preference
6-Step Approach to Opioid Conversion

See Appendix 15 for an opioid conversion table and Appendix 19 for a list of opioid conversion calculators.

1. **Globally assess** the patient to determine if the uncontrolled pain is secondary to worsening of disease or development of a new type of pain.
   - Tip: Treat the patient, not the table.
   - Tip: Use only 1 conversion table.
   - Tip: Start conservatively; then titrate to effect.

2. Determine the **total daily usage of the current opioid**. This should include all long-acting and breakthrough opioid doses.
   - Tip: Calculate doses based on 24-hour usage.
   - Tip: Don’t forget rescue doses.
   - The American Pain Society’s *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain* indicates that dose changes for patients on high doses of opioids may best be accomplished in stages by first implementing a partial conversion in order to minimize the risks of serious miscalculation (withdrawal, severe pain, overdose).
     - For example, a patient being changed from an intravenous to an oral opioid preparation might have his/her infusion decreased by 50%, with the remaining 50% of the opioid requirement provided by an oral formulation.
     - Reassessment of this strategy can be made after 24 hours.

3. Decide which **new opioid analgesic** will be used and consult the established conversion tables to arrive at the proper dose of the new opioid, recognizing the limitations of the data.
   - Remember that the doses listed are just estimates and can vary; the optimal dose for any individual patient is always determined by careful titration and appropriate monitoring.
   - Comparisons between IM and IV doses of different opioids are not always clear. It is recommended that IV doses be based on 2 assumptions:
     - Half the IV dose will give the same peak effect as a single IM dose
     - IV and IM total doses should be equal when calculating the 24-hour requirements since IM doses are eventually fully absorbed.
   - If switching to any opioid other than methadone or fentanyl, decrease the dose by 25% to 50%.
   - If switching to methadone, reduce the dose by 75% to 90%.
   - If switching to transdermal fentanyl, do not reduce the dose.
4. **Opioid rotation** for patients on high doses is not straightforward and may require consultation and possibly hospitalization, especially when switching to methadone.

5. **Individualize the dose** based on information gathered in Step 1, and ensure adequate access to breakthrough medication.
   - Take the half-life of opioids into consideration when changing patients to different opioids.
     - Estimates of doses will vary widely depending on the half-life of the initial and replacement opioid, sometimes resulting in doses several times as large as the original dose.
     - When there is concern that inadequate treatment of severe pain during opioid conversion may result from underdosing due to safety concerns about overestimating the conversion dose, hospitalization during dose conversion may be appropriate.

6. **Follow up with the patient** and **continually reassess**, especially during the first 7 to 14 days, to fine-tune the total daily dose (long-acting plus short-acting) and increase (or decrease) the around-the-clock long-acting dose accordingly.
   - **Tip:** Know the medications you are using.
   - **Tip:** Get help.
Continuing Opioid Therapy

- Continuation of opioid therapy is appropriate under the following circumstances:
  - The patient is doing well on the current analgesic regimen:
    - Satisfactory pain relief
    - Stable or improving function
    - Tolerable side effects
    - Compliance with the rules of therapy
  - The patient’s therapy is not optimal, but working with the current opioid is appropriate.
- If the patient’s regimen is suboptimal, the modifications in the following table should be considered.
- If the modifications to the current regimen suggested in this table do not solve the problem, then alternatives should be pursued (opioid rotation or exit strategy; see pages 21, 27).
## Adjusting Current Opioid: Common Scenarios

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed doses only (eg, oxycodone ER 40 mg q12 hrs)</strong></td>
<td></td>
</tr>
<tr>
<td>Side effects (with good pain relief)</td>
<td>• Decrease dose</td>
</tr>
</tbody>
</table>
| Inadequate pain relief (but no significant side effects) | • Increase dose  
• Add nonpharmacologic therapy (see Appendix 12) |
| Inadequate pain relief (with side effects) | • Add a nonopioid analgesic* (see Appendix 12)  
• Lower opioid dose  
• If possible, treat specific side effect  
• Add nonpharmacologic therapy (see Appendix 12)  
• Rotate opioids (see page 21) |
| Breakthrough pain in a compliant patient | • Add a short-acting opioid for breakthrough pain (see page 14 and Appendix 13) |
| Compliance problems | • Reinforce treatment agreement (see Appendix 18)  
• Re-triage patient (see page 11) |
| **As-needed doses only (eg, hydrocodone/acetaminophen 1-2 tabs tid prn)** |  |
| Side effects (with good pain relief) | • Decrease dose |
| Inadequate pain relief (but no significant side effects) | • Increase dose, but do not exceed maximum recommended amount  
• Add long-acting opioid if improving patient convenience would be useful (see page 14 and Appendix 13)  
• Add nonpharmacologic therapy (see Appendix 12) |
| Inadequate pain relief (with side effects) | • Add a nonopioid analgesic* (see Appendix 12)  
• Lower opioid dose  
• If possible, treat specific side effect  
• Add nonpharmacologic therapy (see Appendix 12) |
| Requirement for frequent prn doses is inconvenient (but no significant side effects) | • Add a long-acting opioid in fixed doses (see page 14 and Appendix 13) |
### Fixed background opioid and prn opioid

| Compliance problems                                                                 | • Reinforce treatment agreement (see Appendix 18)  
|                                                                                     | • Re-triage patient (see page 11)  
|                                                                                     | • Consider replacing prn opioid with fixed-dose long-acting opioid  |
| Side effects occur after prn doses (with good pain relief)                         | • Decrease dose of prn medication  |
| Side effects all the time                                                          | • Decrease background dose |
| Inadequate pain relief around the clock (but no significant side effects)          | • Increase background dose  |
| Prn doses do not adequately relieve breakthrough pain (but no significant side effects) | • Increase dose of prn medication  |
| Inadequate pain relief (with side effects)                                         | • Add a nonopioid analgesic* (see Appendix 12)  
|                                                                                     | • Lower opioid dose  
|                                                                                     | • If possible, treat specific side effect  
|                                                                                     | • Add nonpharmacologic therapy (see Appendix 12)  |
| Requirement for frequent prn doses is inconvenient (but no significant side effects) | • Increase background dose  |
| Compliance problems                                                                 | • Reinforce treatment agreement (see Appendix 18)  
|                                                                                     | • Re-triage patient (see page 11)  
|                                                                                     | • Consider eliminating prn medication  |

* Note potential presence of nonopioid analgesics in combination products; see pages 14-15 and Appendix 12.
Exit Strategy: Tapering/Discontinuation

- Review exit strategy algorithm (see Appendix 16).
- Document lack of pain reduction and/or lack of functional improvement.
- Reinforce with patient that exit criteria were specified in Patient Medication Agreement.
- Distinguish between abandoning opioid therapy, abandoning pain management, and abandoning patient.
- Taper off opioid therapy, with or without specialty assistance.
- Continue nonopioid pain management and general medical care.
Glossary

**Abuse**  The use of a substance to modify or control mood or state of mind in a manner that is illegal or harmful to oneself or others. Examples of the potential consequences of harmful use include accidents or injuries, blackouts, legal problems, and sexual behavior that increases the risk of HIV infection.

**Addiction**  A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. Characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, craving, and continued use despite harm.

**Diversion**  Redirecting the supply of legally obtainable medications into illegal channels or the obtaining of a controlled substance by an illegal method.

**Misuse**  The use of a substance in a manner not consistent with legal or medical guidelines, such as altering dosing or sharing medicines, which has harmful or potentially harmful consequences. Misuse can be intentional or unintentional. Does not refer to use for mind-altering purposes.

**Physical Dependence**  A state of adaptation that is manifested by a withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, or administration of an antagonist.

**Pseudoaddiction**  Abuse-like behaviors that may develop in response to the undertreatment of pain. Examples include becoming focused on obtaining medications, “clock watching,” and other “drug seeking” behaviors.

**Psychoactive Substance Use**  The use of a psychoactive drug in a socially accepted or medically sanctioned manner to modify or control mood or state of mind, in the absence of harmful consequences or a pattern of use likely to lead to harmful consequences. Examples include having a drink with a friend or taking an antianxiety agent for an acute anxiety state in accordance with a physician’s prescription.

**Tolerance**  Loss of a drug’s effects over time, or the need to increase the dose to maintain the effect.

**Withdrawal**  A syndrome that occurs due to the cessation or reduction of prolonged use of a drug. Acute opioid withdrawal is characterized by dysphoria, nausea or vomiting, muscle aches, lacrimation, rhinorrhea, pupillary dilation, diarrhea, yawning, fever, or insomnia.
Appendix 1

Instructions for Office Staff: Setting Up a System for Safe Opioid Prescribing

- Inform your patients about their legal responsibilities with respect to controlled substances.
  - Some offices choose to put up a sign, such as the one in Appendix 3, which is based on Massachusetts law.
    - In using such a sign, consider whether to include the phrase regarding the office’s policy about calling the police.
    - Other offices choose to incorporate this information in patient education materials provided to patients receiving controlled substances.
- Flag charts of all patients on opioid therapy in a private and nonstigmatizing manner, eg, with a colored sticker. Charts can be flagged for each patient visit.
- Use only tamper- and copy-proof prescription pads; serialized pads are even better.
- Secure the prescription pads as you would cash.
- For electronic medical records (EMR) systems, use software that includes automatic dosing safeguards and alerts the PCP when there are frequent opioid prescriptions for an individual patient.

Urine Toxicology

- Develop an arrangement with a provider for Quantitative Urine Medication Monitoring appropriate to opioid therapy. While accepted standards are not yet available, consider the following guidelines:
  - The laboratory assay should be as specific as possible (ie, fewest false-positive drug identifications).
  - The assay should have the lowest limit of quantification possible, in order to avoid false-negative results (ie, the drug was present but not detected).
  - The test MUST be able to distinguish between one prescribed opioid and another.
  - The test should also detect other prescribed controlled medications (eg, benzodiazepines), illicit drugs, and alcohol.
  - The laboratory should offer consultation with a clinical pathologist experienced in urine medication monitoring when questions arise, which is inevitable.
Patient Visits

- Have the patient provide a urine specimen before seeing the PCP.
  - Advise patients to refrain from urinating for as long as possible prior to the visit and to arrive early for these procedures.
- Schedule patient for necessary blood tests, if endocrine laboratory tests have not been obtained or are older than 12 months.
- Have the patient complete the Mental Health Screening Tool (see Appendix 8), if not previously completed or screen is older than 12 months.
- Provide the patient with the Patient Education Brochure (see Appendix 17).
- Set up examination room as follows:
  - To ensure the required tools are readily available, in each room where the clinician will be evaluating patients, set up a file organized by type of visit (eg, initial patient assessment, opioid trial initiation, follow-up visit, etc). Insert copies of the tools listed in Appendix 4 to create a packet that can be quickly removed and added to the patient’s chart.

- Prepare patient’s chart: ensure it includes information appropriate to the type of patient visit as follows:

<table>
<thead>
<tr>
<th></th>
<th>Initial Patient Assessment Visit</th>
<th>Follow-up Visits for Patients on Opioid Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrine laboratory test results</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Exit strategy tool (see Appendix 16)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Follow-up visit form (see Appendix 14)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Initial patient evaluation guide (see Appendix 6)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medication flow chart (see Appendix 2)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mental health screening tool (completed by patient; see Appendix 8)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient medication agreement (signed by patient; see Appendix 18)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Prescription monitoring report (most recent copy; in states where the PMR is available)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Triage tool (see page 11)</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Urine medication monitoring results (and all past results)</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

Note: These instructions for office staff should be placed where only office staff can see them and should not be accessible to patients.
# Appendix 2

*Medication Flow Chart*

Patient name _______________________ Patient ID ___________________

Allergies _______________________________________________________

<table>
<thead>
<tr>
<th>Medication Name (brand/generic)</th>
<th>Date of Prescription</th>
<th># of Dosage Units (eg, 90)</th>
<th># of Refills</th>
<th>Days' Supply (eg, 30 days)</th>
<th># of Refills</th>
<th>Days' Supply (eg, 30 days)</th>
<th>Strength (eg, 25 mg)</th>
<th>Directions (eg, 1-2 tabs tid prn)</th>
<th>Date Due for New Prescription Refilled</th>
<th>Date Due for New Prescription Refilled</th>
<th>Date and Reason for Discontinuation of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

**Controlled Substances Policy Notice**

It is a felony under state* law, punishable by fine and imprisonment, to obtain or attempt to obtain possession of a controlled substance by means of forgery, fraud or deception, including forgery or falsification of a prescription or nondisclosure of a material fact in order to obtain a controlled substance from a practitioner. It is our policy to report this crime to the police.

*This notice is based on Massachusetts statutes and is only valid for Massachusetts. Reprinted with permission from Berkshire Health Systems, Inc., Pittsfield, Massachusetts.

Appendix 4

**Tools for the PCP to Use During Office Visits**

<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Patient Assessment</td>
<td>Initial Evaluation Guide (see Appendix 6)</td>
</tr>
<tr>
<td></td>
<td>SOAPP (see Appendix 7)</td>
</tr>
<tr>
<td></td>
<td>Triage Guide (see page 11)</td>
</tr>
<tr>
<td></td>
<td>Mental Health Screening Tool (see Appendix 8)</td>
</tr>
<tr>
<td></td>
<td>Urine medication monitoring (see Appendix 10)</td>
</tr>
<tr>
<td>Opioid Trial Initiation</td>
<td>Patient Medication Agreement (see Appendix 18)</td>
</tr>
<tr>
<td></td>
<td>Medication Table (see Appendix 13)</td>
</tr>
<tr>
<td></td>
<td>Patient Education Brochure (see Appendix 17)</td>
</tr>
<tr>
<td>Follow-Up Visit</td>
<td>Follow-up Visit Form (see Appendix 14)</td>
</tr>
<tr>
<td></td>
<td>Medication Flow Chart (see Appendix 2)</td>
</tr>
<tr>
<td></td>
<td>Urine medication monitoring (see Appendix 10)</td>
</tr>
<tr>
<td></td>
<td>Prescription Monitoring Program Report (see page 7)</td>
</tr>
<tr>
<td></td>
<td>Endocrine lab tests (annually) (see Appendix 10)</td>
</tr>
<tr>
<td>Conversion to Long-Acting Opioid</td>
<td>Conversion/Rotation Tool (see page 21 and Appendix 15)</td>
</tr>
<tr>
<td>Opioid Rotation</td>
<td>Conversion/Rotation Tool (see page 21 and Appendix 15)</td>
</tr>
<tr>
<td>Taper Opioid Therapy</td>
<td>Exit Strategy for Discontinuing Opioid Therapy (see Appendix 16)</td>
</tr>
</tbody>
</table>
Appendix 5

Recognizing Prescription Opioid Abusers

General Indicators

- Deteriorating personal appearance and hygiene
- Appears intoxicated
- Appears sedated or confused (eg, slurred speech, unresponsive)
- Expresses worries about addiction
- Exhibits lack of interest in rehabilitation or self-management
- Abuses alcohol or uses illicit drugs
- Arrested by police
- Victim of abuse
- Increasingly negative moods
- Mood swings appear to occur at similar times of the day
- Overly reactive to admonishments or compliments
- Increasingly complains about coworkers, family, or friends
- Worsened relationships with family
- Concern expressed by family or significant others over patient’s use of analgesics
- Deliberately avoids coworkers and supervisors, especially those who have been trained to spot abusers
- Careless; makes frequent mistakes and shows poor judgment
- Involvement in car or other accident (3.6 times more likely to have an accident at work and 9 times more likely to have a domestic or car accident)
- Frequent and recurring financial problems
**Work-Related Indicators**
- Frequently late to work
- Requests early dismissal or time off (2.2 times more often)
- Frequently uses sick leave (3 times more often)
- Frequently files worker compensation claims (5 times more likely)

**Medication-Related Indicators**
- Purposeful oversedation
- Uses pain medication in response to stress
- Uses analgesics prn when prescription is for time-contingent use
- Uses more analgesic than prescribed
- Requests frequent early renewals/runs out of medications early
- Reports lost or stolen prescriptions
- Attempts to obtain prescriptions from other doctors
- Hoards/stockpiles medication
- Buys medication on the street
- Changes route of administration
- Insists on certain medications by name
- Expresses a strong preference for a specific type of analgesic or a specific route of administration
- Expresses concern about future availability of controlled substance
- Misrepresents analgesic prescription or use
- Indicates he/she “must have” analgesic
- Predominant issue of office visit is discussion of analgesic medication
- Reports minimal/inadequate relief from opioid analgesic
- Difficulty adhering to medication agreement

Note:
- Some of these behaviors can be normal.
- None are diagnostic.
- Take a therapeutic approach with your patient.
- Set limits.
Appendix 6

Initial Evaluation Guide

History of Present Illness (Pain)

Assessment: What and How

• Several assessment tools are available (see Appendices 7, 14 and 19). These tools provide a systematic process for characterizing the pain, aspects of previous treatment, and effect of pain on other dimensions of the patient’s life.

• Specific questions:
  – What is the type of pain?
  – Where is it located?
  – How severe is it?
  – What makes it worse?
  – What makes it better?
  – What side effects were experienced with previous pain relief therapies?
  – What is the effect on the patient’s mood or energy?
  – What was the patient’s pain level on average during the past week?

Adapted from Janssen Pharmaceutica Products, LP. Pain Assessment and Documentation Tool (PADT). 2003.

– How much has pain affected your life?
– Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference? (yes or no)
– Previous pain treatments?
– Previous experience with opioid therapy?
  • Effectiveness on pain and function?
  • Compliance?
  • Subjective experience with opioid therapy (eg, euphoria)?
  • Use of opioids for nonprescribed purposes (insomnia, “stress,” mood)?
History and Physical Examination: Features Relevant to Substance Abuse

History

Past Medical History
- Illnesses relevant to opioid therapy (eg, respiratory, hepatic, renal disease)
- Medical illnesses suggestive of substance abuse
  - Hepatitis
  - HIV
  - TB
  - Cellulitis
  - Sexually transmitted diseases
- Elevated liver function tests
- Trauma, burns

Psychiatric History
- Current or past mental illness (see Appendix 8 for Mental Health Screening Tool)
- History of substance abuse, including alcohol and tobacco
  - None
  - Past, in remission
  - Current
- Which substance(s); routes; prescription drugs?

Social History
- Arrests
- Motor vehicle accidents; driving under the influence
- Domestic violence
- Fires
- Contact with substance abusers

Family History
- Substance abuse
- Family support
Physical Examination

Skin
• Abscesses, cellulitis, and tissue necrosis—signs of drug use
• Parallel needle marks; hyperpigmentation overlying a vein
• Palpably sclerotic veins
• Trauma to skin (eg, abrasions, lacerations, cigarette burns)

Head and Neck
• Perforation of nasal septum, especially for those using stimulants
• Poor dentition (especially opioid and stimulant abusers)

Chest
• Cardiac disease (all types of drug users)
• Pulmonary disease due to smoking drugs (although most drug abusers are also heavy tobacco users)
• Pulmonary diseases due to suppression of respiration and cough reflex

Abdomen
• Hepatomegaly and liver tenderness due to hepatitis
• Splenomegaly in parenteral drug users

Lymphatic System
• Adenopathy, especially in groin and axillae (common in injection drug users)

Nervous System
• Peripheral neuropathies, sometimes secondary to tissue necrosis from injection; in alcohol and drug abusers

Additional Lab Tests (see Appendix 10)
• Urine medication monitoring
• Endocrine tests
• Other blood tests as appropriate
### Appendix 7

**SOAPP: Screener and Opioid Assessment for Patients With Pain (Short Form)**

<table>
<thead>
<tr>
<th>SOAPP Question</th>
<th>Rate on Scale of 0-4 (0 = never; 4 = usually, or frequently)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you have mood swings?</td>
<td></td>
</tr>
<tr>
<td>2. How often do you smoke a cigarette within an hour after you wake up?</td>
<td></td>
</tr>
<tr>
<td>3. How often have you taken medication other than in the way that it was prescribed?</td>
<td></td>
</tr>
<tr>
<td>4. How often have you used illegal drugs (for example, marijuana, cocaine, etc) in the past 5 years?</td>
<td></td>
</tr>
<tr>
<td>5. How often, in your lifetime, have you had legal problems or been arrested?</td>
<td></td>
</tr>
</tbody>
</table>

**Total**

See page 42 for scoring directions.

Appendix 8

Mental Health Screening Tool

Circle the number that indicates the best answer.

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the past month, how much of the time were you a happy person?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2. How much of the time, during the past month, have you felt calm and peaceful?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3. How much of the time, during the past month, have you been a very nervous person?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. How much of the time, during the past month, have you felt down-hearted and blue?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. How much of the time, during the past month, did you feel so down in the dumps that nothing could cheer you up?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Sum of Answers _______

FINAL SCORE _______

See page 42 for scoring directions.

Adapted from Mental Health Inventory-5 (MHI-5). Crown Copyright © National Electronic Library for Health.
Appendix 9

Scoring SOAPP and the Mental Health Screening Tool

Scoring the SOAPP: Screener and Opioid Assessment for Patients With Pain (Short Form) (see Appendix 7)

Score > 4 indicates patient at risk (see page 40).

Abbreviated versions of the SOAPP have been found to have an alpha coefficient of 0.74, and receiver operating characteristics area under the curve of 0.881 (P < 0.001), suggesting adequate sensitivity and specificity of the abbreviated SOAPP when compared with other self-report screening tools, positive urine toxicology screens, and/or ratings by staff regarding a patient with a drug problem.1

Additional information about SOAPP or copies of other versions can be found by visiting www.painedu.org.

Suggested Reading


Scoring the Mental Health Screening Tool (see Appendix 8)

1. Add up the points, and write the total at the bottom of the right column (Sum of Answers) (see page 41).

2. To get the Final Score:
   Subtract 5 from the Sum of Answers.
   Divide by 20.
   Multiply result by 100.

   \[
   \text{Calculate: } \frac{(\text{Sum of Answers} - 5)}{20} = \text{______} \times 100 = \text{Final Score} \]

3. A Final Score of less than 52 is clinically significant and should trigger a mental health referral to a practitioner experienced with chronic pain.

Suggested Reading

Appendix 10

Laboratory Tests

Qualitative Urine Medication Monitoring

- Urine tests should be conducted to include screening for
  - Cocaine
  - Heroin
  - Amphetamines
  - Marijuana
  - Prescription opioids
  - Benzodiazepines
  - Alcohol
- Unobserved urine collection is usually acceptable.
- In most circumstances, urine testing at every visit is recommended.
- A number of aspects of the urine can indicate it has been adulterated. Work out testing protocols with the provider for urine toxicology testing.
- Develop a relationship with a lab (see Appendix 1).
- If any unexpected lab results are found,
  - Consult with the laboratory about their significance.
  - Schedule an appointment with the patient to discuss results.
    - Positive, supportive approach enhances readiness to change and motivational enhancement therapy (MET) opportunities.
    - Use results to strengthen the healthcare professional–patient relationship and to support positive behavior change.
  - Chart results and interpretation.
- Cause of “false positives”:
  - Some opioids are metabolized to other compounds:
    - Codeine is metabolized to morphine.
    - Hydrocodone is metabolized to hydromorphone.
  - PCPs should therefore not be alarmed if these opioids are found in the urine of patients they are treating with codeine or hydrocodone.
  - Contact the lab directly if you have any questions about test results.
- Cause of “false negatives”:
  - Absence of a prescribed opioid in the urine can also occur for technical reasons, and this alone does not indicate that the patient is not taking the medication.
**Blood Tests**

Opioid-induced hypogonadism is a common complication of opioid therapy in both men and women, in some studies occurring in the majority of patients. Symptoms may be subtle and include fatigue, mood changes, decreased libido, loss of muscle mass, and osteoporosis. Routine screening for opioid hypogonadism is indicated for all patients on long-term opioid therapy. Depending on clinical presentation, some of the following tests may be indicated*:

**Screening of Men**
- Hormone evaluations**
  - Total testosterone
  - Sex hormone binding globulin (SHBG)
  - Luteinizing hormone (LH) (follicle stimulating hormone [FSH] optional)
  - Free testosterone
  - Prolactin

**Screening of Women**
- Hormone evaluations**
  - Total testosterone
  - Sex hormone binding globulin (SHBG)
  - Luteinizing hormone (LH)
    - May be low from opioids
  - Follicle stimulating hormone (FSH)
    - Should be elevated in menopause but may be low from opioids
  - Free testosterone
  - Prolactin
  - Dehydroepiandrosterone sulfate (DHEAS)
  - Free cortisol (serum)
    - Often low in women on opioids

**Premenopausal women (not on oral or transdermal contraceptives)**†
- If patient is not having menstrual cycles, it could be a sign of opioid effect or pregnancy.
  - Pregnancy test (if suspected)

**Women on hormonal contraceptives or estrogen therapy**‡
- SHBG levels may be elevated from oral estrogen administration.
- LH/FSH levels may additionally be lowered from oral or transdermal estrogen therapy.
- Free testosterone levels may be even lower than in postmenopausal women not on estrogen therapy or estrogen/progestin therapy, or premenopausal women not on oral or transdermal contraceptives.
Note: Testosterone therapy is not yet established for women; there are no specific recommendations for monitoring therapy. Premenopausal women who have stopped menstruating may want to go on oral contraceptives concurrently with opioids to protect against irregular ovulations and unwanted pregnancy.

*Courtesy of Norman A. Mazer, MD, PhD. [Boston University School of Medicine, Boston, Massachusetts.]

**Hormone samples are preferably obtained between 7 am and noon.

†If women are having menstrual cycles, obtain sample between days 3 and 8.

‡Samples can be obtained at any time in ovulation cycle, preferably in morning for standardization.

Suggested Reading


Appendix 11

Screening and Brief Intervention in the Primary Care Office

PCPs have an opportunity to identify early signs of substance abuse by doing the following:

- Conduct screening for substance abuse.
  - Assess patient for signs of emerging substance abuse (see Appendices 5 and 14).
  - Screen patient using the following questions:
    - In the past year, have you ever used alcohol, other drugs, or your prescription medication more than you meant to?¹⁰
    - Have you felt you wanted or needed to cut down on your use of prescription pain medication in the past year?¹⁰
- A “yes” response, or other positive indicators, indicates the possibility of emerging substance abuse. In such cases, the PCP should recite the following script, adapted to a specific situation, to the patient when clinical judgment supports the possibility of emerging substance abuse:

  I’m concerned that your use of __________________ is more than is medically safe. I am especially concerned that you might be developing a problem with your use of the medication. Others who have used this medication the way you are using it have had serious medical problems or, in some cases, have even stopped breathing. If not already a problem, you may begin to have 1 or more of the following difficulties:

  - Mood swings that affect your relationships with family and friends at work or school
  - Worsening of your personal appearance and hygiene, and increasing carelessness, which can cause problems at work or school as well as at home
  - Car accidents or accidents at home

For patients who have been unable to remain compliant with medications or other substances despite clear feedback:

I recommend that we begin to gradually withdraw your opioid pain medication. We will accomplish this by reducing the dose of ______________, which you are currently taking, by half every ____________ days until you are completely off the medication. In its place, I recommend that we begin treating your pain with ________________________. This is a non-narcotic way of treating you that I believe will be effective and has no risk of addiction.
For patients who may be compliant, but have signs of potential emerging addiction:

I will arrange for you to see ________________________, an addiction specialist I trust, who will help evaluate your situation and provide recommendations for treatment. I also recommend that you join a support group for people like yourself who have problems with prescription medications or other substances. The nearest one to your home is located at the following address, and meetings are held every ______________ at _____________ o’clock.

I’m going to continue to work with you through this process and have arranged a follow-up appointment to see you again in 2 weeks. I don’t want you to be discouraged; change is difficult, but I know you can do this.

• If referring the patient, ask the addiction specialist to provide summary reports on the patient’s progress.
• Rescreen patient annually for substance abuse.

Suggested Reading

Appendix 12

Nonpharmacologic and Nonopioid Analgesic Treatment of Chronic Pain

• In most cases, the treatment of pain should begin with nonpharmacologic measures with or without pharmacotherapy:
  – Ice
  – Heat
  – Corsets
  – Exercise
  – Rehabilitation
  – Cognitive-behavioral therapy

• If these measures are ineffective, a variety of nonopioid analgesic medications are also available, including those in the following tables. Potential side effects are noted.

Nonopioid Analgesics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Potential Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Liver failure (rare, and most likely with overdose or history of alcohol abuse)</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Abdominal pain, bleeding, edema, mental status change, nausea/vomiting, pruritus/rash</td>
</tr>
<tr>
<td>Nonselective NSAIDS</td>
<td>Abdominal pain, bleeding, congestive heart failure, constipation, edema, headache, hypertension, nausea/vomiting, pruritus/rash</td>
</tr>
<tr>
<td>COX-2–selective NSAIDS</td>
<td>Abdominal pain, congestive heart failure, edema, headache, hypertension, nausea/vomiting, pruritus/rash, cardiovascular thrombosis</td>
</tr>
</tbody>
</table>

NSAIDS = nonsteroidal anti-inflammatory drugs
## Adjuvant Analgesics

<table>
<thead>
<tr>
<th>Medication</th>
<th>Usual Starting Dose and Interval</th>
<th>Common Dosage Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline (Elavil®)</td>
<td>25 mg po hs (10 mg in frail, elderly)</td>
<td>50-150 mg po hs</td>
</tr>
<tr>
<td>Desipramine (Norpramin®)</td>
<td>25 mg po hs (10 mg in frail, elderly)</td>
<td>50-200 mg po hs</td>
</tr>
<tr>
<td>Nortriptyline (Aventyl®, Pamelor®)</td>
<td>25 mg po hs (10 mg in frail, elderly)</td>
<td>50-150 mg po hs</td>
</tr>
<tr>
<td><strong>Anticonvulsants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine (Tegretol®)</td>
<td>100 mg po bid</td>
<td>200 mg po bid-qid</td>
</tr>
<tr>
<td>Clonazepam (Klonopin®)</td>
<td>0.25-0.5 mg po tid</td>
<td>0.5-1 mg po tid</td>
</tr>
<tr>
<td>Duloxetine (Cymbalta®)</td>
<td>60 mg/day po</td>
<td>120 mg/day</td>
</tr>
<tr>
<td>Gabapentin (Neurontin®)</td>
<td>100 mg po tid increase by 100 mg tid q 3 days</td>
<td>300-3600 mg/day in 3 divided doses</td>
</tr>
<tr>
<td>Pregabalin (Lyrica®)</td>
<td>100 mg po tid; start 50 mg tid; increase to 300 mg/day over 7 days</td>
<td>Max: 300 mg/day</td>
</tr>
<tr>
<td>Valproic Acid (Depakene®)</td>
<td>125 mg po tid</td>
<td>500-1000 mg po tid</td>
</tr>
<tr>
<td>Divalproex (Depakote®)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anxiolytics – Azapirones</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buspirone (BusPar®)</td>
<td>5 mg po tid</td>
<td>Max: 60 mg/day</td>
</tr>
<tr>
<td>Venlafaxine (Effexor®)</td>
<td>75 mg bid or tid (immediate-release tablets) or qd (extended-release tablet) Increase of up to 75 mg/day every few days</td>
<td>Max: 225 mg/day Some patients may benefit from higher doses. Monitor blood pressure and lipids</td>
</tr>
<tr>
<td>Medication</td>
<td>Usual Starting Dose and Interval</td>
<td>Common Dosage Range</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Anxiolytics – Benzodiazepines</strong> (Note: all benzodiazepines cause additive sedation with opioids)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alprazolam</strong> (Xanax®)</td>
<td>0.25-0.5 mg po qd-tid</td>
<td>Minimum effective dose</td>
</tr>
<tr>
<td><strong>Chlordiazepoxide</strong> (Librium®)</td>
<td>10-25 mg po qd-tid</td>
<td>Minimum effective dose</td>
</tr>
<tr>
<td><strong>Diazepam</strong> (Valium®)</td>
<td>5-10 mg po qd-bid</td>
<td>Minimum effective dose</td>
</tr>
<tr>
<td><strong>Lorazepam</strong> (Ativan®)</td>
<td>0.5-2 mg po qd-tid</td>
<td>Minimum effective dose</td>
</tr>
<tr>
<td><strong>Midazolam</strong> (Versed®)</td>
<td>Doses vary depending on individual patient needs</td>
<td></td>
</tr>
<tr>
<td><strong>Corticosteroids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dexamethasone</strong> (Duralone®)</td>
<td>Dexamethasone 40-100 mg IV or equivalent as loading doses or q 6 h for first 24-72 h (if indications are acute spinal cord compression, increased ICP) Dexamethasone 4-8 mg po q 8-12 h Prednisone 20-40 mg po q 8-12 h (if indications are nerve compression, visceral distension, increased ICP, soft-tissue infiltration) Dexamethasone 4-12 mg/d Prednisone 5-10 mg tid (if indications are alleviation of nausea, anorexia, pain in palliative care)</td>
<td>Dexamethasone 10-20 mg IV q 6 h or Methylprednisolone 40-80 mg IV q 6 h Minimum effective dose</td>
</tr>
<tr>
<td><strong>Methylprednisolone</strong> (Decadron®)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Miscellaneous Adjuvant Analgesic Agents

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Route</th>
<th>Maximum Oral Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baclofen</strong> (Lioresal®, Atrofen®)</td>
<td>5-10 mg po tid-qid</td>
<td>80-120 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intrathecal:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300-800 µg/day</td>
</tr>
<tr>
<td><strong>Clonidine</strong> (Duraclon®)</td>
<td>30 µg/hr (epidural)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Doses &gt; 40 µg/hr</td>
</tr>
<tr>
<td></td>
<td></td>
<td>not well studied</td>
</tr>
<tr>
<td><strong>Mexiletene</strong> (Mexitil®)</td>
<td>150-300 mg po tid</td>
<td>150-300 mg po tid</td>
</tr>
<tr>
<td><strong>Octreotide</strong> (Sandostatin®)</td>
<td>50-100 µg SC bid-tid</td>
<td></td>
</tr>
<tr>
<td><strong>Pamidronate</strong> (Aredia®)</td>
<td>90 mg IV q 4 weeks</td>
<td>90 mg IV q 4 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>proven effective</td>
</tr>
<tr>
<td><strong>Radio Pharmaceuticals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strontium-89 Chloride</strong> (Metastron®)</td>
<td>148 MBq, 4 mCi IV q 3 months</td>
<td>148 MBq, 4 mCi q 3 months</td>
</tr>
<tr>
<td><strong>Samarium Sm 153 Lexidronam</strong> (Quadramet®)</td>
<td>1.0 mCi/kg IV</td>
<td></td>
</tr>
</tbody>
</table>

### Psychostimulants

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Route</th>
<th>Maximum Oral Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dextroamphetamine</strong> (Dexedrine®)</td>
<td>2.5-5 mg po qd or bid; last dose before 2 pm</td>
<td>5-20 mg in divided doses; last dose before 2 pm</td>
</tr>
<tr>
<td><strong>Methylphenidate</strong> (Ritalin®)</td>
<td>2.5-5 mg po qd or bid; last dose before 2 pm</td>
<td>5-20 mg in divided doses; last dose before 2 pm</td>
</tr>
<tr>
<td><strong>Modafinil</strong> (Provigil®)</td>
<td>200 mg po qd</td>
<td>200 mg qd; occasionally patients may benefit from increasing to 400 mg qd</td>
</tr>
</tbody>
</table>

bid = twice daily; hs = at bedtime; ICP = intracranial pressure; IV = intravenous; MBq = megabecquerel; mCi = millicurie; po = by mouth; q = every; qd = daily; qid = 4 times a day; SC = subcutaneous; tid = 3 times a day

Adapted from Scott CJ, Griffin CB. Pain management table and guidelines. Boston: Dana-Farber Cancer Institute/Brigham & Women’s Hospital; 2000.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Recommended Starting Dose (adults &gt; 50 kg)/Frequency</th>
<th>Recommended Starting Dose (child/adult &lt; 50 kg)/Frequency</th>
<th>Duration (hours)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oral/Parenteral</td>
<td>Oral/Parenteral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine Phosphate/ Sulfate</td>
<td>15-60 mg/3-6 hrs</td>
<td>15-60 mg/4-6 hrs IM/SC</td>
<td>4-6</td>
<td>May be used for treatment of mild to moderate pain in conjunction with acetaminophen. (Analgesic and antitussive properties.) Available as a combination with acetaminophen.</td>
</tr>
<tr>
<td>(Tylenol® with Codeine,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenaphen® with Codeine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fentanyl Citrate</td>
<td></td>
<td>0.5-1 mg/kg/4-6 hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV: Sublimaze®, TD: Duragesic®, Ionsys®, Buccal: Actiq®, Fentora®</td>
<td>100-200 mcg; no more than 4 doses/day; transmucosal</td>
<td>1-2 mcg/kg IV (Bolus)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocodone HCL</td>
<td>2.5-10 mg/3-6 hrs</td>
<td>0.2 mg/kg/3-6 hrs</td>
<td></td>
<td>Available as a combination medication with acetaminophen (Lortab®, Lorcet®); aspirin (Lortab® ASA); ibuprofen (Vicoprofen®).</td>
</tr>
<tr>
<td>Hydromorphone HCL (Dilaudid®)</td>
<td>2-4 mg/3-4 hrs</td>
<td>0.06 mg/kg/3-4 hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levorphanol Tartrate (Levo-Dromoran®)</td>
<td>2-4 mg/6-8 hrs SC</td>
<td>0.04 mg/kg/6-8 hrs SC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meperidine HCL (Demerol®)</td>
<td>50-150 mg/3-4 hrs</td>
<td>1.1-1.8 mg/kg/3-4 hrs</td>
<td></td>
<td>Not recommended due to the metabolite normeperidine, which may accumulate and cause seizures.</td>
</tr>
<tr>
<td>Methadone HCL (Dolophine®, others)</td>
<td>5-10 mg/6-8 hrs SC</td>
<td>0.2 mg/kg/6-8 hrs</td>
<td></td>
<td>Extra potent when used chronically; specialty consultation is advised when converting patients to methadone. Wait 1 week between dose increases. See summary of FDA Public Health Advisory warning below.†</td>
</tr>
</tbody>
</table>

† See summary of FDA Public Health Advisory warning below.
**OPIOID ANALGESICS**

ASA = acetylsalicylic acid (aspirin); IM = intramuscular; IV = intravenous; PO = oral; SC = subcutaneous; TD = transdermal.

Note: Published tables vary in the suggested doses. Clinical response is the criterion that must be applied for each patient; titration to clinical response is necessary. Because there is not complete cross-tolerance among these drugs, it is usually necessary to use a lower dose when changing drugs and to retitrate to response.

Long-acting or extended-release (ER) medications typically are designed with a coating, shell, or capsule that acts to delay the release of active medication. Patients should therefore always be cautioned not to chew such medications but rather to swallow them whole.

† Because of recent unexpected deaths related to methadone, the FDA has issued a Public Health Advisory warning (1) patients should take methadone exactly as prescribed; (2) patients taking methadone should not start or stop taking other medicines or dietary supplements without talking to their healthcare provider; and (3) healthcare professionals and patients should be aware of the signs of methadone overdose (see www.fda.gov/cder/drug/advisory/methadone.htm).

* Once the daily morphine requirement is established, conversion to extended- or sustained-release formulation can be considered. Dosing should be equivalent to the patient’s daily morphine requirement. For example, assuming a patient has a daily morphine requirement of 180 mg of MSIR, extended-release formulations such as MS Contin should be given 60 mg tid (total daily dose: 180 mg) or 90 mg bid (total daily dose: 180 mg).

<table>
<thead>
<tr>
<th>Morphine Sulfate (MS Contin®, Duramorph®, Astramorph®, MSIR®, Kadian®)</th>
<th>MSIR: 15-30 mg/3-4 hrs prn*</th>
<th>10 mg SC; 10 mg IM; 2-4 mg IV/3-4 hrs</th>
<th>0.3 mg/kg/4-6 hrs</th>
<th>0.1 mg/kg SC/IM/4-8 hrs</th>
<th>3-6</th>
<th>Main alkaloid of opium. Prototype of opiate agonists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodeone HCL (OxyContin®, Roxicodone®)</td>
<td>10 mg/12 hrs for (OC) 5-10 mg/3-4 hrs for (R)</td>
<td>--</td>
<td>0.2 mg/kg/3-4 hrs</td>
<td>--</td>
<td>8-12 (OC) 3-4 (R)</td>
<td>Available as a combination medication with acetaminophen (Percocet®, Roxicet®, Tylox®); aspirin (Percodan®).</td>
</tr>
<tr>
<td>Oxymporphone HCL (Numorphan®)</td>
<td>Not available</td>
<td>1-1.5 mg SC; 1.5 mg IM; 0.5 mg IV/3-6 hrs</td>
<td>Not recommended</td>
<td>Not recommended</td>
<td>3-6</td>
<td>Available as 5 mg rectal suppository; 1 suppository = 5 mg/4-6 hrs</td>
</tr>
<tr>
<td>Oxymorphone HCL (Opana®)</td>
<td>10 mg/4-6 hrs</td>
<td>--</td>
<td>Not recommended</td>
<td>--</td>
<td>3-6</td>
<td></td>
</tr>
<tr>
<td>Oxymorphone (Opana ER®)</td>
<td>5-10 mg/12 hrs</td>
<td>--</td>
<td>Not recommended</td>
<td>--</td>
<td>3-6</td>
<td></td>
</tr>
<tr>
<td>Propoxyphene HCL (Darvon®)</td>
<td>65-100 mg/4 hrs</td>
<td>--</td>
<td>Not recommended</td>
<td>--</td>
<td>4-6</td>
<td>Weak analgesic; not recommended as first-line opioid. Available as a combination medication with acetaminophen (Darvocet-N, Wygesic®); aspirin (Darvocet-N with ASA); aspirin and caffeine (Darvon-N compound).</td>
</tr>
<tr>
<td>Tramadol HCL (Ultracet®, Ultram®, Ultram® ER)</td>
<td>50-100 mg/4-6 hrs 100 mg/24 hrs</td>
<td>--</td>
<td>Not recommended</td>
<td>--</td>
<td>4-6 24</td>
<td></td>
</tr>
</tbody>
</table>

ASA = acetylsalicylic acid; IM = intramuscular; IV = intravenous; PO = oral; SC = subcutaneous; TD = transdermal.

Note: Published tables vary in the suggested doses. Clinical response is the criterion that must be applied for each patient; titration to clinical response is necessary. Because there is not complete cross-tolerance among these drugs, it is usually necessary to use a lower dose when changing drugs and to retitrate to response.

Long-acting or extended-release (ER) medications typically are designed with a coating, shell, or capsule that acts to delay the release of active medication. Patients should therefore always be cautioned not to chew such medications but rather to swallow them whole. Caution: Doses listed for patients with body weight less than 50 kg cannot be used as initial starting doses in babies less than 6 months of age.

* Because of recent unexpected deaths related to methadone, the FDA has issued a Public Health Advisory warning (1) patients should take methadone exactly as prescribed; (2) patients taking methadone should not start or stop taking other medicines or dietary supplements without talking to their healthcare provider; and (3) healthcare professionals and patients should be aware of the signs of methadone overdose (see www.fda.gov/cder/drug/advisory/methadone.htm).

* Once the daily morphine requirement is established, conversion to extended- or sustained-release formulation can be considered. Dosing should be equivalent to the patient’s daily morphine requirement. For example, assuming a patient has a daily morphine requirement of 180 mg of MSIR, extended-release formulations such as MS Contin should be given 60 mg tid (total daily dose: 180 mg) or 90 mg bid (total daily dose: 180 mg).
Appendix 14

Follow-up Visit Form

Analgesia

If zero indicates “no pain” and 10 indicates “pain as bad as it can be,” on a scale of 0 to 10, what is your level of pain for the following questions?

• What was your pain level on average during the past week? (Please circle appropriate number.)

![Pain Scale]

- No pain
- Pain as bad as it can be

• What was your pain level at its worst during the past week? (Please circle appropriate number.)

![Pain Scale]

- No pain
- Pain as bad as it can be

• What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.) _______________%

• Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference?
  ☐ Yes  ☐ No
Activities of Daily Living
• Please indicate whether the patient’s functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient’s last assessment. (Please check the box for Better, Same, or Worse for each item below.)

<table>
<thead>
<tr>
<th></th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical functioning</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Family relationships</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Social relationships</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Mood</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Sleep patterns</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Overall functioning</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

Adverse Events
• Is the patient experiencing any side effects from current pain relievers?
  ❑ Yes     ❑ No
• Ask the patient about potential side effects:

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Vomiting</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Constipation</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Itching</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Mental cloudiness</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Sweating</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Fatigue</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Reduced libido</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Other___________________</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

• Patient’s overall severity of side effects?
  ❑ None    ❑ Mild    ❑ Moderate    ❑ Severe
Aberrant Behaviors Checklist (see also Appendix 5)
Check all behaviors that apply.

**Addiction behaviors—since last visit**
- Used illicit drugs or evidences problem drinking
- Has hoarded medications
- Used more opioid than prescribed
- Ran out of meds early
- Has increased use of opioids
- Used analgesics prn when prescription is for time-contingent use
- Received opioids from more than one provider
- Bought medications on the streets

**Addiction behaviors—within current visit**
- Appears sedated or confused (eg, slurred speech, unresponsive)
- Expresses worries about addiction
- Expresses a strong preference for a specific type of analgesic or a specific route of administration
- Expresses concern about future availability of opioid
- Reports worsened relationships with family
- Misrepresents analgesic prescription or use
- Indicates she or he “needs” or “must have” analgesic medications
- Requests office visit primarily to discuss analgesic medication
- Exhibits lack of interest in rehab or self-management
- Reports minimal/inadequate relief from opioid
- Indicates difficulty with using patient medication agreement

**Other**
- Significant others express concern over patient’s use of analgesics
- Other ____________________________________________

**Additional Studies/Tests**
- Urine medication monitoring (see Appendix 10)
  - Positive  □  Negative
  (Positive = presence of nonprescribed controlled medication, illicit substance, or alcohol)
• Blood tests, including endocrine tests

• Prescription monitoring report (if available)
  • Indicates inappropriate behaviour
  • Indicates appropriate behavior
  • Report not available

Comment: ________________________________________________________________

Assessment
• Is your overall impression that this patient is benefiting from opioid (analgesic) therapy?
  • Yes
  • No
  • Unsure

Comments: ________________________________________________________________

Action Plan
☐ Continue present opioid regimen

Adjust regimen as follows:
  • Add/adjust concomitant therapy ________________________________
  • Add/adjust nonpharmacologic therapy ________________________________
  • Adjust present opioid ________________________________
  • Rotate opioid ________________________________
  • Exit strategy: taper patient off opioid regimen __________________
  • Other: ______________________________________________________________________

Comments: ________________________________________________________________

__________________________________________________________________________

Date: _________ Physician’s signature: ____________________________

## Appendix 15

### Opioid Conversion

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equianalgesic Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>IM/IV/SC: 120 mg PO: 200 mg</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1-0.2 mg</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>20-30 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>IM/IV/SC: 1.3-1.5 mg PO: 7.5 mg</td>
</tr>
<tr>
<td>Levorphanol</td>
<td>IM/IV/SC: 2 mg PO: 4 mg</td>
</tr>
<tr>
<td>Meperidine*</td>
<td>IM/IV/SC: 75 mg PO: 300 mg</td>
</tr>
<tr>
<td>Methadone</td>
<td>IM/IV/SC: 1-10 mg' Short term: 5-10 mg</td>
</tr>
<tr>
<td></td>
<td>Chronic use: 1-4 mg (2 mg) PO: 2-20 mg'</td>
</tr>
<tr>
<td></td>
<td>Short term: 20 mg Chronic use: 2-4 mg (3 mg)</td>
</tr>
<tr>
<td>Morphine</td>
<td>IM/IV/SC: 10 mg PO: 30-60 mg†</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>15-30 mg (20 mg)</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>IM/IV/SC: 1 mg PO: 10 mg</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>130-200 mg†</td>
</tr>
</tbody>
</table>

IM = intramuscular; IV = intravenous; PO = oral; SC = subcutaneous.

*Meperidine should be used for acute dosing only and not used for chronic pain management (meperidine has a short half-life and a toxic metabolite: normeperidine). Its use should also be avoided in patients with renal insufficiency, chronic heart failure, hepatic insufficiency, or the elderly because of the potential for toxicity due to accumulation of the metabolite normeperidine. Seizures, confusion, tremors, or mood alterations may be seen.

†Many equianalgesic tables underestimate methadone potency—more studies are needed. Parenteral: Program utilizes 10 mg for short-term dosing and 2 mg for chronic dosing. Oral: Program utilizes 20 mg for short-term dosing and 3 mg for chronic dosing.

‡Acute dosing (opiate naive): 60 mg. Chronic dosing: 30 mg.

§Propoxyphene HCL: 130 mg; Napsylate: 200 mg (not recommended for chronic pain management and therefore not listed above).

Adapted with permission from D. McAuley, GlobalRPh, Inc. www.globalrph.com/narcoticonv.htm
Appendix 16
Exit Strategy for Discontinuing Opioid Therapy

<table>
<thead>
<tr>
<th>The possibility of subsequent discontinuation from opioid therapy should be discussed with the patient at the time that opioid therapy is initiated.</th>
</tr>
</thead>
</table>

## Determine if risk benefit of opioid therapy in this patient does not warrant continued use.

Suggested criteria:
- Intolerable side effects at the minimum dose that produces effective analgesia
- Reasonable attempts at opioid rotation unsuccessful
- Persistent noncompliance with patient care agreement
- Rational close escalation without adequate analgesia
- Deterioration in physical, emotional, or social functioning attributed to opioid dose

## Establish collaborative relationship with patient around need for discontinuation of opioid therapy.

- Review exit criteria agreed upon in patient care agreement
- Clarify that exit is for patient’s (not doctor’s) benefit
- Clarify that exiting opioid therapy is not synonymous with abandoning pain management or abandoning patient

### Patient appears to have a problem with drug addiction.
- Refer for addiction management or comanagement.

### No apparent addiction problem. Patient able to cooperate with office-based taper.
- Taper opioids gradually over 1 month.
- Implement nonopioid pain management strategies, including psychosocial support, cognitive-behavioral therapies, physical therapy, nonopioid analgesics, management of insomnia, anxiety, depression.

### Patient unable or unwilling to cooperate with outpatient taper.
- Provide sufficient opioid for 1-month taper to last until opioid management is transferred.
- Refer to inpatient program or comprehensive outpatient program, or similar services as available.
What is an opioid?
An opioid is a powerful pain medication available only by prescription. Sometimes called narcotics, opioids include morphine, heroin, oxycodone, oxymorphone, methadone, and codeine. Opioids are associated with a significant potential for addiction and abuse.

What is opioid abuse?
Opioid abuse is a pattern of overuse of opioid medication(s) that leads to social, work, and health problems. Relationships with family, friends, and coworkers may be impaired by an individual’s dependence and need to obtain increasing amounts of opioids.

What are the signs of opioid abuse?
- Deterioration of personal appearance and hygiene
- Appearing intoxicated or sedated or confused
- Increasingly negative moods and mood swings
- Exaggerated reactions to criticism or compliments
- Increasing complaints about coworkers, family, or friends
- Carelessness; making frequent mistakes and showing poor judgment
- Involvement in a car accident (3.6 times more likely to have an accident at work and 9 times more likely to have a car accident or accident at home)
- Frequent and recurring financial problems
- Frequent tardiness at work
- Requests for early dismissal (2.2 times more often)
- Frequent use of sick time (3 times more often)
- Frequent filing of worker compensation claims (5 times more likely)
- Purposeful oversedation
- Use of pain medication in response to stress
- Use of more medication than prescribed
- Reporting lost/stolen prescriptions
- Requesting frequent early renewals/running out of medications early
- Attempting to obtain prescriptions from other doctors
- Buying medication on the streets
• Legal problems: arrests; driving under the influence; domestic violence
• Contact with substance abusers

**Medication Dos and Don’ts**

• Do secure your meds in a lockbox or other secure manner.
• Do communicate with your doctor if medications aren’t working or you have side effects.
• Do tell your doctor if you’ve had a problem with drugs or alcohol in the past so that he/she can prescribe the best pain medication possible for you.
• Don’t share your opioid medications with others.
• Don’t hoard your medications; if you are concerned you will not get the treatment you need in the future, share those concerns with your doctor.
• Don’t drink alcohol or take other narcotic or sedative medications together with your current opioid treatment without your doctor’s approval.
• Do dispose of leftover medications when you are done with them.
• Do tell your physician if you are pregnant.

When beginning opioid therapy, you may be asked to sign a **Patient Medication Agreement** and agree that

• You will receive opioid prescriptions only from your primary care physician.
• You agree not to ask for opioid medications from any other doctor without the knowledge and assent of your primary care physician.
• You agree to keep all scheduled medical appointments.
• You agree to provide urine samples for drug testing.
• No prescriptions will be refilled early.
• No prescriptions will be refilled if lost or destroyed, or if any of your medication has been stolen.
• Prescription refills will be authorized only during regular office hours.
• You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended.

**For More Information**

• Common opioid medication side effects and practical measures to minimize them: see www.painaction.org/painaction/Article.aspx?channelId=2&contentId=117
Appendix 18

Patient Medication Agreement

This agreement is between ____________________________________ (patient name) and ____________________________________ (physician name) and ____________________________________ (name of nurse practitioner or physician assistant) of ____________________________________ (name of practice).

The purpose of this agreement is to allow us to prescribe for you to treat your chronic pain. Because these drugs have potential for abuse, strict accountability is necessary.

You are entitled to dignified, sensitive care for a serious medical condition. Complete pain relief is not likely, but our goal is for you to have reduced pain and a better quality of life as a result of the therapy.

Treatment with medication has both risks and side effects. Please review the following and sign the form indicating your agreement. Your therapy will be explained to you, including likely benefits, risks, side effects, and other potential problems with the therapy.

Risks

• There is a risk of physical dependence and, in some cases, addiction to the medication.
• There are serious risks in mixing mind-altering drugs or substances (including alcohol, marijuana, narcotics, sedatives, and sleeping pills) with controlled substances.
• Taking other drugs or substances while on therapy could result in excessive drowsiness and oversedation and could lead to serious injury or death.
• If you take controlled substances while pregnant, your child may be born with a physical dependency on those substances or otherwise be physically harmed.

Side Effects

• It is impossible to predict which opioid side effects you may experience. Having side effects on one opioid does not necessarily mean there will be side effects on another opioid.
• Drowsiness is a common side effect of opioids. Other common, usually temporary, side effects include upset stomach, itching, and sweating. Psychological depression and lowered hormone levels may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs and often does not improve with time.

Discontinuing or Changing Medication

• Opioid medications may need to be discontinued under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic dose escalation, or inability to comply with the treatment agreement.
• Physical dependence will develop with regular use and a withdrawal syndrome will develop if you stop your medication abruptly. Physical dependence does not by itself indicate addiction.
• Symptoms of withdrawal include pain, nausea, diarrhea, anxiety, sweating, and tremor seizures. Your primary care physician (PCP) may direct a slow taper to avoid these side effects.
I understand and agree

- To only take my prescriptions as directed
- That there are risks and the potential for negative side effects from therapy involving controlled substances
- To not use any alcohol, sedating medicines, or other prescribed narcotics during the course of my therapy without permission of my PCP
- To not use any illegal drugs or substances
- To inform my PCP if I choose to stop any of my medicines
- To receive opioid prescriptions only from my PCP or nurse/physician assistant listed above
- Not to ask for opioid medications from any other doctor without the knowledge and assent of my PCP
- To have all my controlled substance prescriptions filled only by the following pharmacy: __________________________________________________________
  phone: ________________________________________________________
- To keep all scheduled medical appointments; I understand that prescriptions will not be renewed if appointments have been missed
- To provide urine samples for drug testing upon request
- To request prescription refills only during regular office hours
- To not request that prescriptions be refilled early
- That no prescriptions will be refilled if lost or destroyed, or if my medication has been stolen; I understand that if I submit a copy of a police report documenting theft of my medication, an exception may be made
- To comply fully with all aspects of my treatment program, including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended
- To immediately inform my PCP if I believe that I may be pregnant; I also agree to inform any provider of prenatal care that I am taking controlled substances therapy

I give permission to my pain doctor to contact my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high-quality care.

I agree with the above restrictions and guidelines and understand that if I do not follow them fully, my doctor may taper and stop opioid treatment or refer me elsewhere for care. A copy of this fully signed agreement will be provided to me.

Patient signature: _________________________________ Date: ____________

Physician signature: _______________________________ Date: ____________

Adapted from Patient Medication Management Agreement. National Initiative on Pain Control (NIPC); American Academy of Pain Medicine; and Berkshire Health Systems, Inc, Pittsfield, Massachusetts.
Appendix 19

Internet Resources

Exit Strategy
www.painknowledge.org

Follow-up Checklist
www.painedu.org

General Pain Sites
www.ampainsoc.org
www.painedu.com
www.painedu.org
www.painknowledge.org
www.partnersagainstpain.com
www.stoppain.org

Laws or Legal Issues Regarding Opioid Treatment
www.fsmb.org
www.deadiversion.usdoj.gov
www.legalsideofpain.com
www.painpolicy.wisc.edu

Opioid Conversion Calculators
www.globalrph.com
www.hopkinskimmelcancercenter.org/specialtycenters/hop.cfm?facilityid=27
www.collectivemed.com
www.medcalc.com
www.painedu.org

Medication and Safety
www.painedu.com
www.painedu.org/articles.asp

Pain Scales
www.painedu.org

Patient Assessment Tools
www.painedu.org
www.painknowledge.org
www.partnersagainstpain.com

Patient Treatment Agreement
www.npecweb.org

Prescribing Drug Monitoring Reports
www.nascsa.org

Preventing and Managing Side Effects
www.painedu.org
www.painaction.org

Resources for Patients
www.drugs.com
www.painedu.com
www.painaction.com/articles.asp
www.pdrhealth.com/drug_info
www.webmd.com/drugs

Support Groups

Addiction
Nar-Anon/Nar-Ateen
www.theagapecenter.com/NarAnon/index.htm

Narcotics Anonymous (NA)
www.theagapecenter.com/NAinUS/

Partnership for a Drug-Free America
www.drugfree.org/Intervention/

Pain
American Chronic Pain Association (ACPA)
www.theacpa.org/people/resources.asp

American Pain Foundation (APF)
www.painfoundation.org/page.asp?file=page_resources.htm
References


Visit PainEDU.org for additional clinician tools and free CMEs.