This care process model (CPM) recommends screening, diagnosis, and treatment processes to help primary care providers improve care and outcomes for patients with chronic pain, defined as **pain persisting beyond three months, and not associated with cancer or the end of life**. The CPM was developed by the Functional Restoration and Chronic Pain Development Team within the Primary Care Clinical Program. It is based on national and local guidelines (listed on back) and shaped by the insights of experts from SelectHealth and Intermountain Healthcare. Related tools such as forms and patient education materials support process implementation.

### Why Focus on Chronic Pain?

- **It's common and expensive.** Estimates of the prevalence of chronic pain patients in primary care range from 5% to 33%. Studies show that over 25% of adults in the US report some form of persistent or chronic pain and that 50 million Americans have chronic pain. In 2004, $13.8 billion was spent on outpatient prescription analgesics, and pain is estimated to cost over $60 billion a year in lost productivity.

- **Opioid abuse and diversion are increasing exponentially in Utah, with associated morbidity and mortality.** From 1999 to 2007, the annual death rate from prescription pain medication poisoning in Utah increased from 39 to 261.

- **Treating patients with chronic pain poses unique and difficult dilemmas.** Concerns associated with chronic pain include comorbid psychological conditions, the potential for a patient’s addiction and abuse, and potential legal liability for physicians.

- **A consistent, best-practice care process can help primary care physicians deal with these dilemmas in several ways.** For example:
  - **Tools** for assessing pain and function, evaluating risk, planning treatment, and monitoring compliance assist in patient management.
  - **Medication tables** for non-opioid analgesics, adjuvant medications, and opioids assist in choosing and titrating medications appropriately.
  - **Guidelines for opioid therapy** — including dosage, opioid rotation, methadone precautions, tapering, and managing potential addiction or diversion — can help reduce the inherent risks in cases where opioid therapy is appropriate.

### CPM Goals

- Make caring for chronic pain patients easier for primary care providers
- Reduce deaths in patients taking opioid medications
- Improve quality of life and function of patients with chronic pain
GUIDING PRINCIPLES

- The primary goal of chronic pain management is relief of suffering and improvement in function. This goal does not imply total absence of pain, which for many chronic pain patients is unrealistic.

- Chronic pain is best managed through an interdisciplinary approach coordinated by the primary care physician, including specialty areas of psychology, physical therapy, and physical rehabilitation. This approach involves the patient as a critical team member who sets goals, participates in a management plan, and tracks his or her progress.

- All patients have the right to adequate pain assessment including documentation of pain location, intensity, quality, onset/duration/variation/rhythms, pain relief and exacerbation, function, and psychological comorbidities. Psychological comorbidities do not invalidate the reality of a patient’s pain.

- Medications are not the sole focus of treatment in managing pain, but should be used when needed to meet overall goals along with other treatment modalities. Long-term opioid therapy should be conducted only in practice settings where careful evaluation, regular follow-up, and close supervision are ensured.

- A universal precautions approach to pain medicine involves monitoring the five A’s listed below in relation to pain medication:
  - Analgesia
  - Adverse effects
  - Abberant behavior
  - Activity
  - Affect

This CPM is designed to help you monitor these factors when medication is used.

- Chronic pain can be prevented. You can help prevent chronic pain by:
  - Treating acute pain appropriately (see page 3 sidebar)
  - Managing chronic medical conditions that increase the risk of developing chronic pain (see page 3)

- CHRONIC PAIN OVERVIEW

  Chronic pain is defined by the International Association for the Study of Pain as “pain that persists beyond normal tissue healing time, which is assumed to be three months.” It may or may not be associated with a pathologic process, and can occur in the context of numerous diseases and syndromes. It can be complicated by psychological comorbidities and a range of contributing factors, and can have a range of effects on daily functioning.

Physiological mechanisms of pain

Identifying the physiological mechanism of chronic pain is useful in choosing the best treatment method, particularly when choosing pharmacotherapy — different physiological mechanisms respond better to different medications.

<table>
<thead>
<tr>
<th>Nociceptive pain</th>
<th>Neuropathic pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause: normal processing by nociceptors in response to noxious stimuli (tissue damage, compression, inflammation, etc.).</td>
<td>Cause: abnormal processing by the peripheral or central nervous system.</td>
</tr>
<tr>
<td>Sensation: based on subtype; see below.</td>
<td>Sensation: Sharp, stabbing, burning, tingling, numb</td>
</tr>
<tr>
<td>Somatic pain:</td>
<td>Peripheraly generated pain:</td>
</tr>
<tr>
<td>From bone, joint, muscle, skin, or connective tissue</td>
<td>includes polyneuropathies (ex: diabetic neuropathy) and mononeuropathies based on peripheral nerve injury (ex: trigeminal neuralgia)</td>
</tr>
<tr>
<td>Localized stabbing, ache, throbbing</td>
<td>Centrally generated pain:</td>
</tr>
<tr>
<td>Visceral pain:</td>
<td>arises from injury to the peripheral or central nervous system (ex: phantom limb pain, spinal cord injury) or dysregulation of autonomic nervous system (sympathetically maintained pain)</td>
</tr>
<tr>
<td>From inflamed or obstructed visceral organs, such as GI tract and pancreas</td>
<td>Vague, diffuse cramping or throbbing, nausea</td>
</tr>
<tr>
<td></td>
<td>Trigeminal neuralgia</td>
</tr>
</tbody>
</table>

Pain syndromes and inflammatory disorders

A myriad of syndromes and conditions can cause chronic pain. It is critical to treat the cause of pain in addition to managing the pain itself. While it is beyond the scope of this CPM to provide specific advice on diagnosing and treating these conditions, see page 27 for links to guidelines and other information that may be helpful.

- Arthritis (osteoarthritis, rheumatoid arthritis)
- Central pain syndrome
- Chronic tendonitis/bursitis
- Headache (chronic daily headache, migraine)
- Chronic low back pain
- Chronic neck pain
- Chronic tendinitis
- Complex regional pain syndrome
- Diabetic peripheral neuralgia
- Fibromyalgia
- Inflammatory bowel diseases
- Interstitial cystitis
- Myofascial pain syndrome
- Neuropathic pain syndromes
- Occipital neuralgia
- Thoracic outlet syndrome
- Trigeminal neuralgia
- Phantom limb pain
- Pelvic pain syndromes
- Post-herpetic neuralgia
- Polyneuropathies
- Sciatica
- Spinal stenosis
Pain-associated chronic conditions and risk factors

Specific chronic medical conditions are associated with chronic pain:
- **Diabetes.** Type 2 diabetes is associated with chronic neuropathic pain.\(^{11}\)
- **Obesity.** Obesity is associated with musculoskeletal pain, particularly low back pain.\(^{12}\)
- **Tobacco use.** Clinical evidence suggests that smoking increases the risk of developing back pain and other chronic pain disorders. Smokers have higher pain intensity scores (with associated impact on functioning) than do nonsmokers.\(^{13}\)
- **Mental health conditions.** Conditions such as depression and anxiety complicate pain, and also serve as risk factors for the development of chronic pain.\(^{14}\)

Intermountain Healthcare provides tools and patient education resources to aid in managing many of these conditions. See the resource summary on page 27 for information on accessing these tools.

Tools for assessing and managing chronic pain

The care process documented in this CPM incorporates tools for:
- **Assessment and monitoring** — including tools to measure pain, function, psychosocial coping mechanisms, mental health, and opioid addiction risk
- **Planning** — an overall pain management plan, plus an opioid therapy agreement for those patients who begin opioid therapy
- **Medication monitoring** — forms to assess misuse of opioids (if they are prescribed) and medication side effects

National guidelines\(^{2,3}\) recommend thorough assessment and monitoring of chronic pain, function, psychosocial factors, addiction risk, medication side effects, and aberrant use of medication; the tools were selected to facilitate these tasks. Individual tools were selected based on their clinical validation, comprehensiveness, and ease of patient and clinician use. Where an easy-to-use, clinically validated tool was not available, it was developed based on expert guidance from the development team. See pages 10 and 11 for a table that summarizes each tool.

While these tools may require some workflow adjustments (see below), they can make patient appointments more efficient and provide a more complete record of treatment outcomes.

Integrating chronic pain tools into practice

Below is one pattern to consider for integrating these tools into practice with a chronic pain patient:
- **First appointment:** Give patient the Pain History Form, Brief Pain Inventory, Pain Coping Survey, and MHI Adult Baseline packet. Ask patient to bring completed forms to a second appointment.
- **Second appointment:** Evaluate the forms and use results to determine treatment. Consider using the Pain Management Plan to set goals and document treatment plan.
- **If you are considering opioid therapy:** Have the patient complete the SOAPP-R or COMM form in the office and use results to inform your decision (see page 9 for risk levels based on scores). Have the patient complete and sign the Opioid Treatment Agreement before you prescribe.
- **Follow-up appointments:** Mail the Brief Pain Inventory, COMM (if patient is on opioid therapy), and Medication Side Effects form to patient before the appointment, with instructions to bring the completed forms.

ACUTE PAIN TREATMENT

Following some basic guidelines can help you prevent acute pain from becoming chronic. The Utah opioid guidelines\(^{1}\) include specific advice on treating acute pain:

- **Try non-opioid therapies.** In most cases, treat acute pain with non-opioid analgesics, physical therapy, or other non-opioid therapies. Consider opioids only if the severity of pain warrants that choice, and after non-opioid strategies do not provide adequate pain relief.
- **Use opioids with caution.** Follow these guidelines if opioids are prescribed for acute pain:
  - Dispense only the number of doses needed, based on the usual duration of pain severe enough to require opioids for that condition.
  - Counsel the patient to store medication securely, not share with others, and dispose of medication properly when the pain has resolved. Intermountain’s Fact Sheet Opioids for Short-term Pain can be helpful.
  - Avoid long-acting medications, except in situations where adequate monitoring and assessment for adverse effects can be done.
- **Re-evaluate, rather than simply continuing opioids, if pain persists beyond the normal time of acute pain treatment.** Continuing opioid treatment may represent the initiation of opioid treatment for chronic pain, without an adequate chronic pain assessment.
  - Review and re-evaluate the diagnosis and treatment of the acute pain condition.
  - Evaluate the patient for comorbidities including depression and/or anxiety.
  - Review the patient’s history for risk factors such as substance abuse or a history of substance abuse, and check the Utah Controlled Substance Database (see page 13).
- **Consider a full chronic pain assessment (see page 4).**
CHRONIC PAIN ALGORITHMS AND TOOLS

ALGORITHM 1: CHRONIC PAIN ASSESSMENT

PATIENT PRESENTS WITH PAIN

HISTORY AND PHYSICAL

1. Perform general medical history/physical exam.
2. Conduct pain history (a) using the Patient History Form.
3. Evaluate pain symptoms and impact on function (b) using the Brief Pain Inventory.

Drug-seeking red flags? (c)

yes →

Check for multiple prescribers and/or meds in urine (d)

Further indication of abuse or diversion?

yes →

Discuss results with patient and consider referral; see page 24 on liability issues and page 25-26 on addiction, abuse, and diversion.

no →

Pain treatment ≥12 weeks?

yes →

no →

Treat as acute pain (see sidebar p. 3) and re-assess in 6 weeks.

DIAGNOSE CAUSE AND TYPE OF PAIN (e)

PSYCHOSOCIAL EVALUATION

1. Screen for mental health status using MHI Adult Baseline Packet (f).
2. Assess psychosocial approach to pain using the Pain Coping Survey (g).
3. Screen for substance use disorder using CAGE-AID questions (h).

Substance use disorder?

yes →

Consult with or refer to addiction specialist.

no →

Go to Chronic Pain Management Algorithm (page 6)
(a) Pain history: Intermountain’s Patient History Form can be used to obtain an effective pain history, including pain onset and duration, providers seen, medications and treatment, and what relieves or exacerbates pain. See Table 1 on page 10 for more information on the Patient History Form.

(b) Pain and function evaluation. The Brief Pain Inventory can be used to evaluate pain symptoms, severity of pain, and interference with function. See Table 1 on page 10 for more information on this form.

(c) Drug-seeking red flags. Department of Justice guidelines and the Utah State Opioid guidelines define behaviors that may indicate a patient is seeking pain medication for the purpose of diversion or abuse. A single red flag does not imply drug-seeking, but multiple behaviors reveal a pattern.

In setting the appointment, the patient:
- Must be seen right away, at the end of office hours, or after hours
- Demands immediate action
- Requests opioids; says meds are lost/stolen

In terms of medical history and records, the patient:
- Has opioid prescriptions from multiple sources (check DOPL database, see p. 13)
- Resists attempts to obtain records or gives reasons why they’re not available (doctor left practice, etc.)
- Has had multiple unnecessary ED visits, esp. for general pain or headache, but hasn’t met ED follow-up recommendations

During history and exam, the patient:
- Shows cutaneous signs — skin tracks or scars (usually multiple, hyper-pigmented, and linear) on neck, axilla, forearm, wrist, foot, and/or ankle
- Gives textbook symptoms OR vague/evasive answers; describes/simulates symptoms that don’t make clinical sense
- Has no interest in diagnosis and wants to self-direct care — fails to appear for diagnostic tests or see other practitioner
- Displays unusual knowledge of controlled substances; may request specific drug (even specific dose) and resist trying anything else
- Describes allergies to non-opioid analgesics, or says they don’t work
- Uses guilt, elicits sympathy, or employs threats to obtain prescription
- “Bad-mouths” other physicians

(d) Further indications of diversion or abuse. The presence of red flags (listed above) may indicate diversion or abuse. The two resources below are used to screen for additional indications — the presence of drugs of abuse, high doses of prescribed medications, and/or multiple medication prescribers:

- Urine drug testing (qualitative immunoassay and quantitative lab test to confirm) — see pages 12 and 13
- Utah Controlled Substance Database — see page 13

(e) Diagnosis of cause and type of pain. Wherever possible, identify and treat the specific condition or syndrome associated with pain. Because it is beyond the scope of this CPM to provide treatment algorithms for all of these, the CPM takes a general approach to managing chronic pain symptoms. However, see page 27 for links to sources that can guide treatment decisions within the general recommendations here.

(f) Mental health status: Mental health conditions and chronic pain are commonly comorbid, and each exacerbates the other. The MHI Adult Baseline Packet aids in assessing mental health conditions and their severity. See Table 1 on page 10 for more information on the packet.

(g) Psychosocial approach to pain (pain coping mechanisms): An assessment of maladaptive cognitions and coping strategies that can worsen pain can help identify patients who need specialized, pain-focused, psychotherapy or a multidisciplinary team approach. The Pain Coping Survey is a subset of the pain coping scales included in the Vanderbilt Multidimensional Pain Coping Inventory, which has been shown effective in predicting positive and negative psychological adjustment to pain. See Table 1 on page 10 for more information on this form; see page 7 for information on using this form to help plan psychosocial treatment.

(h) Substance abuse: For patients with substance use disorder, concurrent treatment of the disorder is an important part of pain management. Screening begins in primary care; a preliminary diagnosis can be confirmed through evaluation by a specialist. A 2008 AHRQ study identified nine instruments potentially useful for substance abuse screening in primary care. Of these, the CAGE-AID (Cut down, Annoyed, Guilty, Eye-opener, Adapted to Include Drugs) is the briefest to administer, with good evidence of accuracy and fair evidence of reliability as a screening tool.

The CAGE-AID is included as question 9 in the MHI Adult Initial History and Consultation form but can also be administered in a clinician interview. The CAGE-AID begins with this question:

First question: Do you drink Alcohol, have you ever experimented with Illegal Drugs, or have you ever used prescription drugs other than as prescribed?

If the patient answers yes, ask the questions below:

- C - Have you ever felt you should cut down on your drinking or drug use?
- A - Have people annoyed you by criticizing your drinking or drug use?
- G - Have you ever felt bad or guilty about your drinking or drug use?
- E - Have you ever felt you needed a drink or other drug in the morning as an eye-opener to steady your nerves or get rid of a hangover?

One “yes” answer indicates a possible problem. Two or more “yes” answers indicate probable substance abuse.
ALGORITHM 2: CHRONIC PAIN MANAGEMENT PLAN AND FOLLOW UP

CHRONIC PAIN ASSESSMENT COMPLETED

PLAN TREATMENT and EDUCATE PATIENT

1. Refer or treat for specific causes and types of pain (a)
2. Identify the most appropriate non-opioid treatment modalities depending on the patient’s situation and pain condition
   - Psychosocial treatment (b)
   - Sleep improvement (c)
   - Physical and/or occupational therapy (d)
   - Self-management (e)
   - Integrative medicine strategies (f)
   - Medical and/or surgical interventions (g)
   - Non-opioid medication (h)
3. Provide patient education on chronic pain, including self-care measures recommended based on the patient’s condition (i).

Patient already on opioid therapy?

yes

no

INITIATE THERAPIES PER TREATMENT PLAN (including NON-OPIOID MEDICATION TRIAL)

FOLLOW UP IN 2-4 WEEKS

FOLLOW UP

1. Check for reduced symptoms and increased function using the Brief Pain Inventory (see page 10).
2. Check for medication side effects using the Medication Side Effects Form (see page 11).

FOLLOW UP EVERY 3 MONTHS

Improved pain and function?

yes

no

ADJUST TREATMENT PLAN

- Consider adjusting pharmacotherapy.
- Consider adding medical interventions, physical therapy, occupational therapy, and/or integrative strategies not yet implemented (see page 14).

Considering opioids?

yes

See OPIOID THERAPY ALGORITHM Page 8
(a) Treatment of specific causes and types of pain.
Treating underlying conditions can sometimes resolve chronic pain, and effective treatment of pain symptoms also depends on the type and cause of pain. See page 27 for a list of resources to help manage specific causes and types of pain.

(b) Psychosocial treatment: Use results of the MHI Adult Baseline Packet and Pain Coping Survey to guide planning.

RESULTS ——> RECOMMENDED PLAN

<table>
<thead>
<tr>
<th>Pain Coping Survey</th>
<th>Consider consult/referral to pain clinic, multidisciplinary program, or mental health provider who specializes in chronic pain*</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHI Adult Baseline Packet indicates one or more mental health condition(s)</td>
<td>Follow the MHI process to evaluate complexity and severity. Consult with or refer to mental health specialist based on severity and complexity, or treat in the primary care environment.</td>
</tr>
</tbody>
</table>

All other patients | Offer mental health consult (patient preference). |

* Pain-focused approaches include interpersonal therapy, motivational interviewing, CBT (cognitive-behavioral therapy), EMDR (eye movement desensitization and reprocessing), or peer support. MHI case managers can assist in evaluating patients and determining the best approach.

(c) Sleep improvement. Multiple studies show a reciprocal relationship between impaired sleep and chronic pain.15,18,19 To address any sleep problems identified during assessment:

- Educate the patient on good sleep habits. Intermountain’s Sleep Habits Fact Sheet offers a helpful summary of sleep hygiene.
- Prescribe medication for sleep if necessary. If opioid therapy is anticipated, avoid benzodiazepines and screen for sleep apnea (see OPIOID THERAPY ALGORITHM).

(d) Physical and/or occupational therapy. Exercise, the most widely used conservative treatment for chronic low back pain, has been shown in systematic reviews to be effective. Compared to usual care, exercise has been shown to improve pain intensity, disability, and long term function.20 Physiotherapy and/or occupational therapy have also been indicated for Complex Regional Pain Syndrome21, diabetic neuropathy (if gait is affected)22, and osteoarthritis of the hip and knee.23

(e) Self-management. The following strategies are recommended:

- Tobacco cessation
- Sleep improvement
- Weight loss for patients who are overweight or obese
- Exercise
- Meditation or relaxation strategies

(f) Integrative medicine strategies. Patients may enter your practice having tried various strategies such as acupuncture, massage therapy, hypnosis, biofeedback, or herbal remedies. Some of these strategies have been proven helpful, depending on patient

and type/etiology of pain; see page 14 for a brief review. If a patient is using a particular strategy, it is recommended to follow this aspect of treatment to help the patient prevent harm, and support the strategy if the patient finds it effective in relieving pain and improving function.

Based on your background and comfort level, you may also find it helpful to recommend specific strategies for some patients. Insurance plans rarely cover integrative medicine in full, but may offer partial coverage; counsel patients to check with their insurance to ask about discounts. SelectHealth offers a 25% discount on acupuncture, massage therapy, and chiropractic services through a program called ChooseHealth; refer patients to the SelectHealth website for more information.

(g) Medical or surgical interventions. Refer to specialty care (physiatry, pain specialist, orthopedics, etc.) for medical and/or surgical interventions, if appropriate. Common procedures used to diagnose and treat chronic pain include those listed below. The evidence supporting these procedures is variable; guidelines are available from the American Society of Interventional Pain Physicians.24

- Peripheral nerve injections/nerve blocks
- Peripheral joint injections with local anesthetic, anti-inflammatory medication, or lubricating substances like hyaluronic acid
- Spinal injections, which include medications and/or the use of heat or cold (radiofrequency lesioning procedures)
- Other nerve blocks, such as sympathetic nerve blocks
- Nerve stimulators (including TENS units, peripheral nerve stimulators, spinal cord stimulators and brain stimulators)
- Implanted medication pumps, typically providing infusion of medication into the spinal fluid

(h) Non-opioid medication. Multiple guidelines recommend trying one or more non-opioid analgesics or adjuvant medications before considering opioid therapy. Unless a patient is already taking opioids, begin with non-opioid analgesics.2,3,5,25 See pages 15-16 for recommended non-opioid analgesics and adjuvant medications. If you are considering opioids for an opioid-naive patient:

- Take current substance abuse disorder into account. If there are signs strongly indicating the patient has substance abuse disorder, consult with an addiction specialist before considering opioids.
- Take risk of addiction or abuse into account. Consider administering the SOAPP-R form to assess risk before making your decision (see page 9).

(i) Patient education. Intermountain’s booklet Managing Pain and Living Well provides education for patients on self-management and treatment for chronic pain.

(j) Pain management planning. Working with the patient to define goals and a management plan can reinforce the patient’s key role in pain management. Intermountain’s Pain Management Plan facilitates this process. See Table 1 on page 10 for more information on this form.
Algorithm 3: Opioid Therapy

Patient already on opioid therapy, or non-opioid treatment failed (a)

Evaluate risk of addiction or abuse (b)

- Check Utah’s Controlled Substance Database (see page 13) and consider performing urine drug screen (pages 12-13)
- Administer and evaluate risk assessment:
  - For patients already on opioid therapy, use the Current Opioid Misuse Measure (COMM)
  - For patients not on opioid therapy, use the Screener and Opioid Assessment for People with Pain–Revised (SOAPP-R)

Start short-term trial of opioid therapy

- Before prescribing:
  - Screen and/or test for sleep apnea (c)
  - Provide education on opioids and have patient sign an Opioid Therapy Agreement (d)
- Start with a two-week prescription, ideally with short-acting opioid (e); schedule follow-up appointment in 2 weeks
- Prevent common side effects (see page 18). Use Medication Side Effects Form to identify common side effects.

FOLLOW UP IN 2 WEEKS

Follow-up

- All patients: Screen for adverse effects; evaluate pain and function (f); use COMM form and check the Controlled Substance Database (see page 13) to check for aberrant use and monitor ongoing risk (b).
- Moderate and high-risk patients: In addition, consider using pill counts and/or urine tests on randomly selected visits to check adherence to treatment plan (g)

Suspect abuse, diversion, or addiction?

Yes → Discuss with patient; adjust treatment plan and/or refer patient to addiction specialist. See page 24 on liability risks and page 25-26 on addiction, abuse, and diversion.

No → Adverse side effects?

Yes → Side effects controlled?

Yes → Improved pain and function?

Yes → Maintain & monitor therapy

- Consider switch to long-acting medication with scheduled dosing, if necessary (h)

No → Side effects controlled?

No → Change med/dose, treat side effects

ADJUST TREATMENT

- Change dose or medication; add or adjust non-opioid elements of plan. FOLLOW UP in 2 weeks.

No → Adverse side effects?

No → Yes → HIGH risk (b)?

Yes → Consider referring patient to specialist or pain clinic; make plan for increased monitoring (i). See p. 25 for information on minimizing your liability risk.

No → FOLLOW UP IN 2 WEEKS
(a) When to consider opioid therapy: Based on multiple guidelines, this CPM recommends that opioid therapy be initiated only when all the following criteria are met:
- Pain is moderate to severe, and adequate trials of other treatments and non-opioid analgesics have failed
- The potential benefits outweigh the risks — and clear, measurable treatment goals have been set
- The patient is informed of the risks and benefits and an opioid therapy agreement is in place

(b) Assessing risk of opioid addiction or abuse. Along with the Utah Controlled Substance Database and urine drug tests, the Screener and Opioid Assessment for Patients with Pain—Revised (SOAPP–R®) for opioid-naive patients, and the Current Opioid Misuse Measure (COMM®), for patients currently taking opioids, have been shown to be effective in predicting risk. See the table below on evaluating a patient’s risk of opioid addiction or abuse before prescribing opioids; if any one method results in a high-risk evaluation, consider the patient at high risk.

<table>
<thead>
<tr>
<th>Assessment Method</th>
<th>Utah’s Controlled Substance Database (see page 13)</th>
<th>Urine drug screen (see page 12-13)</th>
<th>SOAPP-R (see page 11)</th>
<th>COMM (see page 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW RISK</td>
<td>Database does not show pain medication prescriptions from multiple sources; prescription history is consistent with patient’s self-report</td>
<td>Results are consistent with the patient’s self-report of current medications and do not indicate drugs of abuse</td>
<td>Score under 10</td>
<td>Score under 6</td>
</tr>
<tr>
<td>MODERATE RISK</td>
<td>Database shows pain medication prescriptions from more than one source, but prescription history is consistent with patient’s self-report</td>
<td>Results are consistent with the patient’s self-report of current medications and do not indicate drugs of abuse</td>
<td>Score 10 to 21</td>
<td>Score 6 to 8</td>
</tr>
<tr>
<td>HIGH RISK (any one of these results)</td>
<td>Database shows pain medication prescriptions from more than one source and prescription history is not consistent with patient’s self-report</td>
<td>Results are not consistent with the patient’s self-report OR indicate drugs of abuse</td>
<td>Score 22 or above</td>
<td>Score 9 or above</td>
</tr>
</tbody>
</table>

(c) Sleep apnea screening/testing. Sleep apnea is a risk factor for opioid-related ataxic breathing during sleep.
- Screen for obstructive sleep apnea using the STOP-BANG or other objective assessment; see Intermountain’s CPM and the accompanying screening questionnaire on this topic.
- Consider sleep study to screen for central sleep apnea if opioid dosage is greater than 100 mg morphine equivalent analgesic dose (see page 22), if patient or family observes abnormal breathing patterns during sleep, or if the patient reports hypersomnia or insomnia.

(d) Education and agreement. Intermountain has developed two resources to help:
- **Opioids for Chronic Pain** is a patient education fact sheet that explains safe opioid use and necessary risk monitoring.
- The **Opioid Treatment Agreement** includes specific agreements related to safety and monitoring. In HELP2, this agreement can be scanned as an image acquisition under Medication Management Agreement; if a scanned image is present, an MMA icon will appear on the patient’s HELP2 record.

(e) 2-week opioid trial. The Utah State Opioid Guidelines recommend a brief trial with short-acting opioid medication before transitioning to scheduled dosing with a long-acting form, if appropriate. See pages 18-19 for more information.

(f) Checking adverse effects; evaluating improvement.
- **Adverse effects**: Check for common adverse side effects using the **Medication Side Effects Form**.
- **Pain symptom improvement**: Consider trending the patient’s answer to question 5 from the **Brief Pain Inventory**.
- **Improvement in function**: Consider trending question 9 (total of subitems) from the **Brief Pain Inventory**.

(g) Checking adherence to the treatment agreement.
- **Pill counts**: Ask the patient to bring medications to the appointment; count pills to determine whether the patient is on track with the prescribed dosage.
- **Urine tests**: See page 12 for information on qualitative (immunoassay) screens for drugs of abuse. See page 13 for information on mass spectrometry tests to confirm the presence of prescribed medication.

(h) Long-acting medication with scheduled dosing:
Consider switching to long-acting medication (appropriate for scheduled dosing, not PRN) if:
- Pain is moderate to severe — and constant or nearly constant
- Pain is not adequately relieved by short-acting opioids, or dosage of short-acting opioids is approaching peak levels
- The patient is experiencing withdrawal symptoms as short-acting opioid medication wears off

(i) Ongoing follow-up and monitoring:
The frequency of follow-up — and the types of checks done during follow-up appointments — should depend on the patient’s risk for opioid addiction or abuse, along with the patient’s pain condition, functional status, and level of pain.

For moderate-risk or high-risk patients:
- Follow up more frequently with face-to-face visits.
- Renew prescription at visit (avoid prescribing 3 months at a time).
- Check adherence to treatment plan using pill counts or urine screens.
## TABLE 1. Chronic pain assessment and management tools

<table>
<thead>
<tr>
<th>Form or tool</th>
<th>Description and scoring</th>
</tr>
</thead>
</table>
| **Pain History Form** (1 page) | When to use: Initial assessment.  
                                 **Description:** Assesses pain onset, duration, providers seen, medications and treatment, and what relieves or exacerbates pain.  
                                 **How to interpret:** Clinical judgement based on physician review. |
| **Brief Pain Inventory** (2 pages) | When to use: Initial assessment AND treatment monitoring.  
                                 **Description:** Helps determine severity of pain and interference with function. Assesses pain location; pain intensity in the past 24 hours (at worst, least, and average); relief provided by medication; and pain interference with seven dimensions of function. While originally developed to assess patients with cancer-related pain, the BPI has also been validated in a study with over 400 chronic nonmalignant pain patients.  
                                 **How to interpret:**  
                                 • Initial assessment provides a baseline.  
                                 • For symptom improvement, consider tracking the answer to question 5.  
                                 • For functional improvement, consider tracking question 9 (total the sub-items). |
| **MHI Baseline Packet** (multiple forms) | When to use: Initial assessment and ongoing follow-up.  
                                 **Description:** Aids in assessing the presence and severity of comorbid mental health conditions that may exacerbate or be exacerbated by chronic pain. Includes the following:  
                                 • **Initial History and Consultation:** Helps identify barriers to effective pain treatment, such as family history of mental illness, chronic medical conditions, sleep problems, abuse/truma, stress, and substance abuse.  
                                 • **Family Rating Scale:** Assesses family’s dominant relational style, which can significantly impact the patient’s support system and outcomes.  
                                 • **Screening forms** for specific mental health conditions, including depression (PHQ9), anxiety/PTSD, mood disorders, and ADHD.  
                                 **How to interpret:** Information on the MHI packets and scoring instructions are available in the MHI Care Process Model and Guide to Scoring and Evaluating Adult MHI Forms. Results can help with planning of overall mental health treatment; see page 7. |
| **Pain Coping Survey** (1 page) | When to use: Initial assessment to help determine whether the patient is a good candidate for pain-focused psychotherapy.  
                                 **Description:** Assesses maladaptive cognitions and coping strategies that can worsen pain; can help identify patients who need specialized psychotherapy focused on pain or a multidisciplinary team approach. The Pain Coping Survey is a subset of the pain coping scales included in the Vanderbilt Multidimensional Pain Coping Inventory, which has been shown effective in predicting positive and negative psychological adjustment to pain. The four scales included are:  
                                 • **Active coping** (exercise or physical therapy, leisure activities, mental distraction, etc.), which indicates a patient feels some control over pain.  
                                 • **Seeking social support**, which measures whether the patient engages a social support system in a healthy way, such as seeking advice and discussing feelings.  
                                 • **Passive coping** (restricting social activities, focusing on pain, heavy reliance on meds, etc.), which indicates a patient believes he/she has no control over pain.  
                                 • **Disengagement** includes feelings of hopelessness, worries about the future, and concluding that pain will never improve.  
                                 **How to interpret:** Use the scoring instructions on the form to derive a score for each of four scales (A, S, P, D) described above. If scales P and D are high, patients should consider offering an MHI consult for pain-focused psychotherapy. |
## TABLE 1. Chronic pain assessment and management tools, cont.

<table>
<thead>
<tr>
<th>Form or tool</th>
<th>When to use</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain Management Plan</strong></td>
<td><strong>(1 page)</strong></td>
<td>Helps you and your patient agree on treatment(s), pain and functional goals, and self-management goals. Includes the following elements:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Functional and pain management goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pain management treatments, including physical/occupational therapy, specialty consultation such as physiatry or neurology, and medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Mental health treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sleep improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Integrative medicine strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Self-care strategies</td>
</tr>
<tr>
<td><strong>Screeners and Opioid Assessment of Patients with Pain—Revised</strong></td>
<td><strong>(SOAPP—R®)</strong></td>
<td>Any time opioid medication is being considered for an opioid-naive patient, before it is prescribed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For opioid-naive patients, the SOAPP—R assessment identifies factors associated with a patient’s risk for addiction or abuse of opioid medication. Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring in long-term opioid therapy and has been validated with chronic pain patients. The form contains 24 items and takes under 10 minutes to complete.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>How to interpret</strong>: Add the ratings of all the questions; see page 9 for risk levels based on scores. A separate document with more detail about this assessment appears on the clinical programs chronic pain topic page.</td>
</tr>
<tr>
<td><strong>Current Opioid Misuse Measure (COMM®)</strong></td>
<td><strong>(2 pages)</strong></td>
<td>Initial assessment and treatment monitoring for patients who are already on opioid therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For patients currently taking opioids, the COMM assessment has been shown to be effective in identifying whether the patient, may be exhibiting aberrant behaviors associated with opioid medication misuse. The form contains 17 items and takes under 10 minutes to complete.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>How to interpret</strong>: Add the ratings of all the questions; see page 9 for risk levels based on scores. A separate document with more detail about this assessment appears on the clinical programs chronic pain topic page.</td>
</tr>
<tr>
<td><strong>Opioids for Chronic Pain fact sheet</strong></td>
<td><strong>(2 pages)</strong></td>
<td>Treatment planning before opioids are prescribed; can be scanned in HELP2 so an icon will appear in the patient’s record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Description</strong>: The patient education fact sheet explains safe use of opioids and the methods a doctor may use to monitor risk. The form includes a range of specific agreements related to safety and monitoring. In HELP2, this agreement can be scanned as an image acquisition under Medication Management Agreement; if a scanned image is present, an MMA icon will appear on the patient’s HELP2 record.</td>
</tr>
<tr>
<td><strong>Medication Side Effects form</strong></td>
<td><strong>(1 page)</strong></td>
<td>Treatment monitoring.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Description</strong>: This form helps identify adverse effects of medication. It lists a range of side effects common to analgesic medication.</td>
</tr>
</tbody>
</table>
Urine drug testing

Urine drug tests are useful in assessing and monitoring patients who may be candidates for opioid therapy.

- **Qualitative tests** show the presence of a drug or drug class, including drugs of abuse, typically using in-office immunoassay. These tests are useful as a screening instrument before prescribing opioids. If results differ from the patient’s self-report or if drugs of abuse are present, and the results are confirmed with a quantitative test, consider patient at high risk for opioid addiction or abuse.

- **Quantitative tests** indicate both the presence and level of a specific medication, using in-lab gas chromatography-mass spectrometry. These tests are useful for confirming a positive result on a qualitative test and for monitoring adherence to an opioid treatment agreement. If results differ from the patient’s self-report, investigate further and discuss the situation with the patient.

Qualitative testing

Intermountain recommends the CLIA-waived RapidTOX immunoassay test from American Bio Medica described in the table below. See the sidebar at left for information on interpreting qualitative test results.

- **Test #**
- **Analytes**
- **Average cassette price**
- **Codes and reimbursement**

<table>
<thead>
<tr>
<th>Test #</th>
<th>Analytes</th>
<th>Average cassette price</th>
<th>Codes and reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-10XT-2000</td>
<td>Amphetamines, barbiturates, benzodiazepines, buprenorphine, cocaine, MDMA (ecstasy), methamphetamine, methadone, opiates (2000 ng/mL), oxycodone, PCP, THC (marijuana)</td>
<td>$3.75 – $4.50</td>
<td>CPT: 80100&lt;br&gt;Medicare: G0430-QW&lt;br&gt;Average reimbursement $18–$20</td>
</tr>
<tr>
<td>RapidChek</td>
<td>Strips show adulterated sample</td>
<td>$25 / 25 strips</td>
<td>n/a</td>
</tr>
</tbody>
</table>

- **How to prepare for in-office use:** Your clinic must have a CLIA license for waived testing to conduct these tests; check with the Laboratory Technical Consultants for your site to ensure this requirement is met.

- **Where to order:** Order from American Biomedica (www.americanbiomedica.com).

- **How to use the RapidTOX test:** Follow the package insert directions or the quick reference guides (see the sidebar at left). Keep these tips in mind:
  - Depending on the volume of urine, you can insert the cassette into the sample or apply several drops of urine into a sample well at the bottom of the cassette.
  - In the test area for each analyte, a negative result is shown by the presence of a test line. A preliminary positive result is shown by the absence of a test line.

- **What to do if results are positive:** See the sidebar at left for more information on interpreting qualitative test results. In many cases, positive results should be treated as preliminary. Conduct a quantitative test to confirm the results, and schedule a follow-up appointment to discuss results with the patient.
Quantitative testing

Intermountain recommends the **ARUP quantitative tests** listed in the table below. See the sidebar at right for information on interpreting quantitative test results.

<table>
<thead>
<tr>
<th>ARUP Test Name*</th>
<th>Analytes and cutoff concentrations</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs of Abuse Confirmation/Quantitation - Opiates</td>
<td><strong>Analytes</strong>: codeine, dihydrocodeine, morphine, 6-acetylmorphine, hydrocodone, hydromorphone, oxycodone and oxymorphone</td>
<td><strong>Positive cutoff</strong>: Not reported if below 5 ng/mL</td>
</tr>
<tr>
<td>Drugs of Abuse Confirmation/Quantitation - Methadone &amp; Metabolite</td>
<td><strong>Analytes</strong>: methadone and metabolite</td>
<td><strong>Positive cutoff</strong>: Not reported if below 10 ng/mL</td>
</tr>
<tr>
<td>Drugs of Abuse Confirmation/Quantitation - Fentanyl &amp; Metabolite</td>
<td><strong>Analytes</strong>: fentanyl and metabolite</td>
<td><strong>Positive cutoff</strong>: Not reported if below 1.0 ng/mL</td>
</tr>
</tbody>
</table>

*Ordering tests: When ordering these tests through your lab service, specify that you need a GC/MS test for confirmation, NOT an immunoassay.

**Using the Utah Controlled Substance Database**

The Utah opioid prescribing guidelines recommend that a patient’s record in the Utah Controlled Substance Database be checked before prescribing opioids, and rechecked quarterly during chronic opioid therapy. To find the Utah Controlled Substance Database, go to [csd.utah.gov](http://csd.utah.gov). Keep these points in mind:

- **As of 2010, all physicians licensed to prescribe controlled substances must register to use the database, take a tutorial, and pass a test** that focuses on the database and the prescribing of controlled substances.

- **If you need a login, click the Register Here link and follow the steps.** You’ll need to provide personal contact info (including a reliable e-mail address), information for three security questions, and your DEA number.

- **You can authorize a member of your clinic staff to check the database on your behalf.** To do this, give written notice to the Division of Occupational and Professional Licensing about the employee. After conducting a brief background check, the division will give the employee a password to the database.

- **To find the online tutorial**, once you have logged in with your PIN click the Training link at the top of the database website.

- **After checking the DOPL database for information on a patient**, it is helpful to document the fact that you checked the database, but you are encouraged NOT to include the DOPL report itself in the patient’s medical record.

**INTERPRETING QUANTITATIVE TEST RESULTS**

The test report lists the concentration of each analyte over the cutoff amount. Various factors can cause the lab report to be different than expected.

- **If prescribed medications are not detected**, possible explanations include medication diversion, diluted urine, accelerated metabolism, or poor drug absorption (due to drug interactions, drug-metabolizing enzymes, or genetic variations).

- **If medications are detected that were not prescribed**, possible explanations include unreported prescriptions, use of non-prescribed drugs, drug metabolism (see details below), or an incorrect prescription.

- **Drug metabolites can influence results.** Common metabolites include:
  - Codeine or heroin to morphine
  - Morphine to hydromorphone
  - Codeine to hydrocodone
  - Hydrocodone to oxycodone or dihydrocodeine

If the lab report shows results that are not expected based on the prescription or patient report, **talk with the patient about the results.** See pages 25-26 for information on talking with patients about potential addiction, abuse, or diversion.
Nonpharmacologic treatment:

- **Fish**
- **Medical/surgical interventions:**
- **Integrative medicine:** with guidance on selecting non-opioid interventions
- **Self-management:**
  - Yoga: Chronic back pain

WHAT ABOUT NUTRITION?

Based on the research evaluating diet and supplements for chronic pain, this CPM recommends the following:

- **Consider a Mediterranean diet for inflammatory pain.** Some studies suggest that a diet rich in vegetables, fruit, fish, and monounsaturated fats—and low in dairy and red meat—may reduce the inflammation present in pain syndromes, particularly rheumatoid arthritis. Consulting with a dietitian is recommended.
- **Consider omega-3 fatty acids for rheumatoid arthritis.** Fish oil supplements have been shown in placebo-controlled studies to improve joint pain and stiffness.
- **Consider ALA and ALC supplements for diabetic neuropathy.** Large randomized trials have shown the benefit of 600 mg per day of alpha lipoic acid (ALA) and 1000 mg per day of acetyl L-carnitine (ALC).
- **The literature is inconclusive about the benefits of glucosamine sulfate and chondroitin for osteoarthritis.** However, as they are safe and may have some beneficial effect when taken in recommended amounts, they can be considered based on patient preference.

**NON-OPIOID THERAPY**

Various pain management guidelines recommend managing chronic pain without opioids whenever possible. The Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain states it this way: “Alternatives to opioid treatment should be tried (or adequate trial of such treatment by a previous provider documented), before initiating opioid treatment.”

Determining non-opioid treatment strategies

Based on your clinical judgement and the patient’s preferences, incorporate one or more of the following strategies in the pain management plan:

- **Treat medical condition(s) that cause pain:** A wide variety of conditions cause chronic pain (see page 2 for examples). Treating the underlying condition can sometimes resolve chronic pain symptoms, and specific conditions respond to different pain management strategies. While it is beyond the scope of this CPM to provide unique algorithms for each condition, see page 27 for links to guidelines on treating some of these conditions — complex regional pain syndrome, diabetic peripheral neuropathic pain, fibromyalgia, headache, neuropathic pain (including diabetic neuropathy and other syndromes), osteoarthritis, pelvic pain, and rheumatoid arthritis. While some of these guidelines may include opioid therapy, they also provide specific advice on the nonopioid medications and strategies that are most helpful for these conditions.
- **Including non-medication-based treatment and self-management:**
  - **Self-management:** All chronic pain patients can benefit from education on sleep hygiene, exercise, meditation or relaxation strategies, tobacco cessation (if the patient smokes), and weight loss (if patient is overweight or obese).
  - **Nonpharmacologic treatment:** Depending on the patient’s condition and preferences, consider psychosocial treatment, physical therapy, and/or occupational therapy. See the sidebar for a summary of recommendations for some of these.
  - **Medical/surgical interventions:** This category contains a range of therapies that are helpful for specific pain conditions; see page 7 for a summary.
  - **Integrative medicine:** Depending on the patient’s condition and preferences, you may want to recommend integrative medicine strategies. See the sidebar for a summary of recommendations for some of these.
- **Prescribing non-opioid medications:** Multiple guidelines recommend trying one or more non-opioid analgesics or adjuvant medications before considering opioid therapy.

**A TOOL TO GUIDE YOU IN USING NON-OPIOID THERAPIES**

In the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain you will find a comprehensive Non-Opioid Pain Management Tool with guidance on selecting non-opioid strategies for 13 specific chronic pain conditions, including back and neck pain, headache, osteoarthritis, neuropathic pain, fibromyalgia, and pelvic pain.

The Utah guideline document is linked on Intermountain’s clinical programs chronic pain topic web page (see page 28). Once you open the Utah guideline, scroll to page 33 in that document to find the tool.
## TABLE 2. Non-opioid analgesics

<table>
<thead>
<tr>
<th>Medication</th>
<th>Typical dosage</th>
<th>SH Tier, Cost†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nonprostaglandin synthase inhibitor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen (APAP)</td>
<td>Varies; do not exceed 4,000 mg/day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Carboxylic acids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin (inc. buffered and enteric)</td>
<td>2,400 to 4,000 mg per day, divided in 4 to 5 doses</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Salsalate (Disalcid)</td>
<td>750 to 1,500 mg, twice daily</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Diflunisal (Dolobid)</td>
<td>250 to 1,500 mg, twice daily</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Choline magnesium trisalicylate (Trilisate)</td>
<td>1,500 to 3,000 mg per day, in 2 to 3 doses</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Propionic acids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ibuprofen (Motrin, Rufen, OTC)</td>
<td>Varies; do not exceed 3,200 mg per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Naproxen, enteric (Naprosyn, Anaprox)</td>
<td>Preferred in this class for patients with risk of CV disease</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Fenoprofen (Nalfon)</td>
<td>300 to 600 mg, 4 times per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Ketoprofen (Orudis, Oruvail)</td>
<td>75 mg, 3 times per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Flurbiprofen (Ansaid)</td>
<td>100 mg, 2 to 4 times per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Oxaprozin (Daypro)</td>
<td>600 mg, twice daily</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Acetic acid derivatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indomethacin (Indocin, Indocin SR)</td>
<td>25 to 50 mg, 3 to 4 times per day; SR: 75 mg, twice daily; do not exceed 150 mg per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Diclofenac (Cataflam); diclofenac plus misoprostol (Arthrotec)</td>
<td>Cataflam: 50 to 75 mg, twice daily; Arthrotec: 50 mg, twice daily</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Etodolac (Lodine)</td>
<td>200 to 300 mg, 2 to 4 times a day; do not exceed 1,200 mg per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Tolmetin (Tolectin)</td>
<td>800 to 2400 mg per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Sulindac (Clinoril)</td>
<td>150 to 200 mg, 2 to 3 times per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Fenamates</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medclofenamate (Meclomen)</td>
<td>50 to 100 mg, 3 to 4 times per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Mefenamic acid (Ponstel)</td>
<td>250 mg, 4 times per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Enolic acids</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meloxicam (Mobic)</td>
<td>7.5 mg per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Piroxicam (Feldene)</td>
<td>10 to 20 mg per day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Phenylbutazone (Butazolidin)</td>
<td>100 mg, 3 times per day, up to 600 mg/day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Naphthylkanone derivative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nabumetone (Relafen)</td>
<td>500 mg, 2 times per day, up to 1500 mg/day</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Naphthylkanone derivative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celecoxib (Celebrex) - Generic not avail.</td>
<td>100 to 200 mg per day</td>
<td>Tier 3, $$$</td>
</tr>
</tbody>
</table>

* Tier: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth 2010 RxSelect benefit design; some benefit designs may differ).

† Cost: Estimated monthly cost based on usual dose. $=$1 to $25; $=$26 to $75; $$$=$76 to $150; $$$=$150 to $300; $$$$$= >$300. Generic used for tier and price comparisons unless otherwise noted.

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### PRECAUTIONS WITH NON-OPIOID ANALGESICS

- **Acetaminophen (APAP):** Do not exceed 4,000 mg/day; for patients with alcoholism or liver disease, do not exceed 2,500 mg/day. Monitor patients taking warfarin when APAP usage changes.
- **Ibuprofen:** Do not exceed 3,200 mg/day.
- **Aspirin:** Do not exceed 4,040 mg per day. If aspirin is used to reduce CV occurrences, it should be taken before an NSAID to maximize anti-platelet effects (see below).

#### General NSAID precautions:

- **Upper GI toxicity:** Combining a PPI or misoprostol with an NSAID prevents stomach ulcers, compared to NSAIDs alone. Celebrex is associated with fewer peptic ulcers, compared to traditional NSAIDs. Piroxicam may have more GI effects than other NSAIDs.
- **Renal toxicity:** NSAIDs worsen renal impairment and should be used judiciously in those with renal impairment (or at risk for it).
- **Cardiovascular:** Celebrex and traditional NSAIDs (except aspirin) have been equally implicated in increased risk of stroke and MI. Increased risk may range from up to 30% (or higher) in at-risk populations. Avoid using NSAIDs for at least 6 months after an acute vascular event or surgery, or during CHF.
- **Platelet aggregation:** Most NSAIDs have platelet impairment that is reversed when the drug is eliminated from the system (about 3 days). Salsalate and Celebrex do not impair platelet function. Aspirin permanently impairs platelets, but overall platelet function is recovered in 7 to 10 days.
- **Increased blood pressure:** NSAIDs in therapeutic doses can increase blood pressure in both normotensive and hypertensive patients.
- **Lower GI toxicity:** NSAIDs worsen colitis.
### TABLE 3. Adjuvant medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Notes and Precautions</th>
<th>SH Tier, Cost†</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antidepressants (TCAs):</strong> amitriptyline (Elavil), desipramine (Norpramin), nortriptyline (Pamelor), imipramine (Tofranil), doxepin (Sinequan, Adapin)</td>
<td>Notes: Helpful for neuropathic pain, back pain (after failing other non-opioid therapies), and headache. Amitriptyline is the most widely studied TCA for chronic pain. Precautions: Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid in patients with cardiac disease or MI history; titrate slowly in elderly patients. Can cause serotonin syndrome, especially if combined with other meds that increase serotonin.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>SNRIs:</strong> duloxetine (Cymbalta), milnacipran (Savella), venlafaxine (Effexor)</td>
<td>Notes: Helpful for headache (after other non-opioids have failed), diabetic neuropathy, and fibromyalgia. Cymbalta is FDA-approved for chronic musculoskeletal pain. Precautions: Can cause serotonin syndrome, especially if combined with other meds that increase serotonin. Avoid Cymbalta in patients who consume alcohol or have hepatic insufficiency. Venlafaxine side effects include nausea, vomiting, sleepiness, and dizziness; most patients adapt to these.</td>
<td>Cymbalta (brand): Tier 2, $$$$$. Savella (brand): Tier 2, $$$. Venlafaxine (generic): Tier 1, $$.</td>
</tr>
<tr>
<td><strong>NDRI:</strong> bupropion (Wellbutrin)</td>
<td>Notes: Helpful for neuropathic pain. Precautions: Can cause serotonin syndrome, especially if combined with other meds that increase serotonin.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Triptans:</strong> naratriptan (Amerge), sumatriptan (Imitrex), frovatriptan (Frova), rizatriptan (Maxalt), zolmitriptan (Zomig)</td>
<td>Notes: Helpful for migraine headache. Med choice within this class depends on migraine profile. Precautions: Can cause serotonin syndrome, especially if combined with other meds that increase serotonin.</td>
<td>Naratriptan and sumatriptan: Tier 1, $. Maxalt, Zomig: Tier 2, $$. Axert, Frova: Tier 3, $$$$</td>
</tr>
<tr>
<td><strong>Anticonvulsants: Primarily indicated in neuropathic/lancinating pain</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gabapentin (Neurontin)</td>
<td>Notes: Approved for postherpetic neuralgia; helpful in neuropathic pain and headache. Precautions: Side effects include somnolence and dizziness; start at low doses; titrate gradually.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Pregabalin (Lyrica)</td>
<td>Notes: Indicated for fibromyalgia, diabetic neuropathy and postherpetic neuralgia. Less frequent dosing than gabapentin. Precautions: May cause euphoria; Schedule V controlled substance. Side effects include dizziness, drowsiness, and peripheral edema. May cause weight gain.</td>
<td>Tier 3, $$$</td>
</tr>
<tr>
<td>Oxcarbazepine (Trileptal)</td>
<td>Notes: Indicated for diabetic neuropathy and trigeminal neuralgia. Similar in action to carbamazepine (see below), with better safety and tolerability profile.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Carbamazepine (Tegeotol), phenytoin (Dilantin)</td>
<td>Notes: Approved for trigeminal neuralgia. Precautions: Test CBC and liver function before starting; consider periodic blood plasma levels while patient is on this medication. Common side effects include drowsiness and ataxia.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Topiramate (Topamax)</td>
<td>Notes: Helpful for prevention and management of migraine headache. Precautions: Can cause kidney stones in some patients; encourage hydration, reduce dose in patients with renal dysfunction. Can cause memory loss, sedation, dizziness, and gastrointestinal upset. Associated with a decrease in appetite; overweight patients often experience weight loss.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Valproic acid (Depakene); divalprox (Depakote); lamotrigine (Lamictal)</td>
<td>Notes: Helpful for neuropathic pain, but generally not the first-line choice. Precautions: Common side effects of valproic acid and divalprox include tremor, peripheral edema, sedation, GI discomfort, weight gain.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baclofen (Lioresal)</td>
<td>Notes: Helpful for neuropathic pain/allodynia, trigeminal neuralgia. Precautions: Common side effects include dizziness, drowsiness, GI symptoms, and respiratory depression.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Propanolol (Inderal)</td>
<td>Notes: Helpful for prevention of migraine headache. Precautions: Side effects include insomonia, hyperglycemia, vomiting, and dizziness.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Cyclobenzaprine (Flexeril), tizanidine (Zanaflex), methocarbamol (Robaxin)**</td>
<td>Notes: Cyclobenzaprine has evidence supporting its use in muscle spasms and fibromyalgia. Tizanidine may be helpful as adjunct treatment for chronic headaches. Methocarbamol is indicated for musculoskeletal pain. Precautions: Common side effects include CNS depression, sedation, dizziness, dry mouth and headache. Cyclobenzaprine: Avoid in patients with cardiac disease. Tizanidine: Avoid or use with caution in patients with renal or hepatic disease.</td>
<td>Tier 1, $</td>
</tr>
<tr>
<td>Lidocaine patch 5% (Lidoderm)</td>
<td>Notes: Approved for treatment of post-herpetic neuralgia. Precautions: Should be worn no more than 12 hours per day; avoid external heat sources or application of more than 3 patches at once. Common side effects include headaches, nausea, dizziness, and skin irritation.</td>
<td>Tier 3, $$$$</td>
</tr>
</tbody>
</table>

* Tier: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). † Cost: Estimated monthly cost based on usual dose. $ = $1 to $25; $$ = $26 to $75; $$$ = $76 to $150; $$$$ = $150 to $300; $$$$$ = $300+ Generic used for tier and price comparisons unless otherwise noted. ‡ SSRIs are not listed in this table because they are generally less effective than other antidepressants in chronic pain management. § Serotonin syndrome: TCAs, SNRIs, and SSRIs increase serotonin, and particularly when combined can cause serotonin syndrome, a potentially fatal condition caused by serotonergic activity in the nervous system. Symptoms include clonus, agitation, mental status changes, diaphoresis, hypotension, tremor, and/or tachycardia. Avoid combining multiple meds that can cause serotonin syndrome. ‡ Avoid Soma: Soma is not listed here because it should be avoided in both acute and chronic treatment, due to the risk of dependency.
OPIOID THERAPY

This section contains information focused on helping physicians maximize the benefits of opioid therapy when it is appropriate, while minimizing the inherent risks posed by opioids. Included are general principles from evidence-based guidelines, information on dosing and side effects, medication tables, information on opioid rotation, additional precautions for methadone, and ways to minimize your legal liability risk.

General principles

- **Consider opioid therapy only if all these criteria are met:**
  - Pain is moderate to severe and adequate trials of other treatments and non-opioid analgesics have failed.\(^2,3,5,25\)
  - The potential benefits outweigh the risks — and clear, measurable treatment goals have been set.\(^2\)
  - The patient is informed of the risks/benefits/alternatives and how to take opioids safely, and has signed an opioid therapy agreement.\(^2\)

- **Start low and go slow.**
  - Start at the lowest dose and titrate to the lowest possible effective dose.
  - Titrate only one opioid medication at a time, and titrate slowly (over 8 to 12 weeks) to help avoid adverse effects. Follow up in face-to-face appointments every 2 to 4 weeks (more often for high-risk patients).
  - Individualize dosing and titration for the patient. The dosing tables in this section provide general guidelines — always take health status, previous opioid exposure, therapeutic goals, and risk factors into account.
  - Take precautions to prevent opioid-related CNS and respiratory depression. Screen for sleep apnea and avoid opioids if it is present. Minimize sedatives, benzodiazepines, barbiturates, and alcohol.

- **Follow-up regularly.** Follow up regularly with the patient in person to assess pain/function, progress toward goals, adverse effects, and adherence to treatment plan. Base appointment frequency — and degree of adherence assessment — on the patient’s risk of addiction or abuse. See page 8 for more information.

- **Look for an exit strategy.** Work with your patient to reduce dose if/as pain problem improves. Discontinue opioids if any of the following conditions is present:
  - Resolution of pain problem
  - No improvement in function or pain; treatment goals are not met
  - Deterioration in physical, emotional, or social functioning attributed to therapy
  - Persistent non-compliance with treatment agreement
  - Adverse effects that are severe, uncontrollable, or that outweigh benefits

- **When it’s time to end opioid therapy, make the decision with the patient.**
  - Review reasons for stopping therapy; clarify that discontinuing opioids are for the patient’s benefit.
  - Refer for addiction management or comanagement if necessary.
  - Affirm that you will continue nonopioid pain management and general medical care.

- **Do not discontinue opioids abruptly.** See page 25 for tapering guidelines.

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NOT FOR EVERY PRACTICE

Chronic opioid therapy is not for every practice. Long-term opioid therapy should only be conducted in practice settings where careful evaluation, regular follow-up, and close supervision are ensured.

MIXED EVIDENCE

The evidence on the efficacy of opioids is mixed. Chronic opioid therapy can be ineffective for pain relief\(^3,34\) and opioids have not been proven to improve function or quality of life.\(^2,3\) Patients should be counseled not to expect complete pain relief — the goal is 40% of baseline measurements.\(^2\)

EDUCATION AND AGREEMENT

Before prescribing chronic opioid therapy, educate the patient about their safe use and establish a monitoring agreement. Intermountain has developed the following tools to help:

- **Opioid Medication for Chronic Pain** (4-page fact sheet). This fact sheet is a companion to the opioid therapy agreement below; it describes risks, side effects, benefits, precautions, and monitoring procedures for chronic opioid therapy.
- **Opioid Therapy Agreement** (1 page). This agreement can be scanned in HELP2 image acquisition, under Medication Management Agreement. If a scanned image is present, an MMA icon will appear on the HELP2 record to alert healthcare providers that the patient is on chronic opioid therapy.
CYP2D6-INHIBITING DRUGS

The medications listed below can affect metabolism of selected opioids; these opioids are noted in the tables that follow. CYP2D6-inhibiting medications include:

- Antiarrhythmics: amiodarone, propafenone, quinidine (strong inhibitor)
- Antihistamines: diphenhydramine, chlorpheniramine (in vitro), brompheniramine (in vitro), tripolidine (in vitro)
- Neuroleptics: chlorpromazine, haloperidol, methotrimeprazine, perphenazine, thioridazine
- Quinine compounds: hydroxychloroquine, quinacrine, quinine
- SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline
- Other: cimetidine, clomipramine, ketoconazole, ritonavir, ticlopidine

MAXIMUM OPIOID DOSES

While there are no evidence-based guidelines for maximum opioid doses, higher opioid doses are associated with increased risk of opioid overuse death. In consensus guidelines, specific opioid maximums vary; the maximum doses in the tables that follow are based on Utah State guidelines and expert guidance from the development team. Close monitoring and follow-up are key. Do not prescribe higher doses than you feel you are qualified to manage.

Preventing and managing side effects

Opioid side effects, with prevention/management strategies, are listed below.

<table>
<thead>
<tr>
<th>Side effect</th>
<th>Prevention/management notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most serious</strong></td>
<td></td>
</tr>
<tr>
<td>Respiratory depression</td>
<td>Screen for sleep apnea and avoid opioids if it is present. Avoid sedatives, benzodiazepenes, barbiturates, and alcohol.</td>
</tr>
<tr>
<td><strong>Most common</strong></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td>Educate patients to increase fiber and fluids; start osmotic agent or stool softener with mild peristaltic stimulant; increase dose if no BM in 48 hours.</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>Consider prophylactic antiemetic therapy. Ondansetron (Zofran) is recommended because it does not interact with opioids.</td>
</tr>
<tr>
<td>Itching</td>
<td>Reduce dose and increase frequency, change opioid, and/or consider antihistamines.</td>
</tr>
<tr>
<td><strong>Less common</strong></td>
<td></td>
</tr>
<tr>
<td>Cognitive effects (such as sedation, confusion)</td>
<td>Reduce dose and/or change opioid; avoid sedatives.</td>
</tr>
<tr>
<td>Perceptual effects (e.g., hallucinations, depression)</td>
<td>Rule out other causes, and eliminate all nonessential CNS-acting medications (e.g., steroids). Reduce opioid dose or switch opioid.</td>
</tr>
<tr>
<td>Sexual dysfunction (inc. hypogonadism)</td>
<td>Rule out other causes. Reduce dose. Testosterone supplementation may be helpful in men.</td>
</tr>
<tr>
<td>Serotonin syndrome</td>
<td>See note at bottom of page 16 for information on serotonin syndrome; avoid combining opioids (particularly tramadol) with medications that increase serotonin.</td>
</tr>
<tr>
<td>Hyperalgesia</td>
<td>Hyperalgesia, the result of a dysfunction of the nociceptive system, results in peripheral and/or central sensitization. Symptoms include widespread pain not consistent with physical findings and/or pain out of proportion to mild stimuli. Animal studies note a lower pain threshold after exposure to sustained opioids. Change the opioid, reduce the dose, or taper the patient off opioid medication.</td>
</tr>
</tbody>
</table>

Opioid selection and dosing considerations

- **When starting opioid therapy, short-acting medications are recommended;** they are generally safer (due to a shorter half-life), lessen the danger of overdose, and are easier to titrate to an effective dose (page 19 has dosing for opioid-naive patients).
- **For longer-term maintenance, consider a transition to long-acting opioids with scheduled dosing IF:**
  - Pain is moderate to severe and constant or nearly constant
  - Pain is not adequately relieved by short-acting opioids or dosage of short-acting opioids is approaching peak levels
  - The patient has withdrawal symptoms as short-acting medication wears off
- **Maximum dosages for opioid combinations:** In prescribing medications that combine opioids with other analgesics, keep in mind the daily maximum doses of those analgesics. Educate patients to avoid use of OTC products containing the same ingredient.
  - Aspirin: maximum dose is 4,000 mg per day.
  - Acetaminophen (APAP): Maximum dose is 3,000 mg to 4,000 mg per day.
  - Ibuprofen: Maximum dose is 3,200 mg per day.
### Table 4. Short-Acting Opioid Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initial Dose</th>
<th>Max Dose*</th>
<th>SH Tier, Cost†</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>15 to 60 mg</td>
<td>8 tablets</td>
<td>w/APAP: Tier 1, $1-2</td>
<td>• Special populations. Use with caution in elderly or frail patients; avoid in hepatic disease; avoid or reduce dose in renal dysfunction.</td>
</tr>
<tr>
<td></td>
<td>(codeine) /</td>
<td>per day</td>
<td>w/Codeine: Tier 1, $1</td>
<td>• Codeine alone is a weak analgesic; more effective alternatives are available (including codeine combined with APAP).</td>
</tr>
<tr>
<td></td>
<td>3 to 6 hrs</td>
<td>(based on APAP maximums)*</td>
<td>alone: Tier 1, $1</td>
<td>• May cause more nausea and constipation than other opioids; 5-10% of Caucasians lack enzyme to metabolize; not the best choice for chronic use.</td>
</tr>
<tr>
<td></td>
<td>w/Aspirin,</td>
<td></td>
<td></td>
<td>• Affected by meds that inhibit CYP2D6.</td>
</tr>
<tr>
<td></td>
<td>butalbital,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>caffeine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>2.5 to 10 mg</td>
<td>8 tablets</td>
<td>w/APAP: Tier 1, $2</td>
<td>• Special populations. Use with caution and start at low end of initial dose range in elderly/frail patients or in hepatic or renal dysfunction.</td>
</tr>
<tr>
<td></td>
<td>(hydrocodone)</td>
<td>per day</td>
<td>w/ibuprofen: Tier 1, $2</td>
<td>• If prescribing combined products, educate patients to avoid use of OTC products containing same ingredient.</td>
</tr>
<tr>
<td></td>
<td>/ 3 to 6 hrs</td>
<td>(based on APAP/ibuprofen maximums)*</td>
<td>alone: Tier 1, $2</td>
<td>• Affected by meds that inhibit CYP2D6.</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2 mg / 4 to 6 hrs</td>
<td>30 mg/day</td>
<td>Tier 1, $3</td>
<td>• Special populations. Use with caution in elderly or debilitated patients or in hepatic or renal dysfunction. Risk of accumulation due to decreased clearance in patients with renal impairment.</td>
</tr>
<tr>
<td>Meperidine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Demerol)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fentanyl buccal</td>
<td>NOT recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Actiq, Fentora, Onsolis, Abstral)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine (MSIR)</td>
<td>15 to 30 mg</td>
<td>90 mg/day</td>
<td>Tier 1, $4</td>
<td>• Special populations. Use with extreme caution and reduce dose in elderly or debilitated patients; use caution and consider reducing dose in hepatic dysfunction. Avoid or reduce dose in renal dysfunction; active metabolites may accumulate in patients with renal impairment and contribute to neurotoxicity, hyperalgesia, alldynia, and myoclonus.</td>
</tr>
<tr>
<td>Tapentadol (Nucynta)</td>
<td>50 to 100 mg</td>
<td>600 mg/day</td>
<td>Tier 3, $5</td>
<td>• Special populations. Helpful for patients prone to nausea and vomiting with other opioids. Prescribe with caution in patients taking SSRIs or tricyclic antidepressants.</td>
</tr>
<tr>
<td>Oxycodone IR</td>
<td>2.5 to 7.5 mg</td>
<td>8 tablets</td>
<td>Tier 1, $6</td>
<td>• Special populations. Reduce dose for elderly or debilitated patients. Use with caution in hepatic or renal dysfunction.</td>
</tr>
<tr>
<td></td>
<td>(oxycodone) / 3 to 6 hours</td>
<td>per day (based on APAP/ibuprofen maximums)*</td>
<td>alone: Tier 1, $6</td>
<td>• Affected by meds that inhibit CYP2D6.</td>
</tr>
<tr>
<td>Oxycodeine IR</td>
<td>5 to 10 mg</td>
<td>40 mg/day</td>
<td>Tier 1, $7</td>
<td>• Use extreme caution in prescribing, due to potential fatal interaction with alcohol.</td>
</tr>
<tr>
<td></td>
<td>/ 4 to 6 hrs</td>
<td>(based on APAP maximums)*</td>
<td>alone: Tier 1, $7</td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td>Ultracet: 37.5 mg / 4 to 6 hours</td>
<td></td>
<td></td>
<td>• Special populations. For elderly patients or those with renal dysfunction, do not exceed 300 mg/day in divided doses. Use with caution in prescribing for debilitated patients. For patients with renal dysfunction, use 12-hour dosing and do not exceed 200 mg/day.</td>
</tr>
<tr>
<td></td>
<td>Ultracet: 8 tablets per day</td>
<td></td>
<td>w/Ultracet: Tier 1, $8</td>
<td>• Ultram initial titration. Start with 25 to 50 mg per day, titrated by 25 to 50 mg increments every 3 days, to reach 50 mg, 4 times daily.</td>
</tr>
<tr>
<td></td>
<td>Ultram: 25 to 50 mg / 24 hours</td>
<td></td>
<td>alone: Tier 1, $8</td>
<td>• Tramadol can increase seizure risk, esp. in patients taking SSRIs, tricyclics, MAOIs, neuroleptics, or other drugs that decrease seizure threshold; in patients with epilepsy or seizure risk; or at &gt;500 mg/day.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Poses higher risk of serotonin syndrome than other opioids; see note at the bottom of page 16.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Affected by meds that inhibit CYP2D6.</td>
</tr>
</tbody>
</table>

* Maximum opioid doses are based on consensus (see 18 sidebar); ensure accurate diagnosis and carefully weigh benefits (pain relief and function) against risk of increased dosage. If unclear, consult a specialist. Maximum dosages of opioid combination products are based on daily maximums of acetaminophen and ibuprofen; see page 18. Patients should be counseled to avoid OTC products containing these analgesics.

† Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $=1 to $2; $5=$26 to $75; $50=$76 to $150; $150=$150 to $300; $300>=$300. Generic used for tier and price comparisons unless otherwise noted.

‡ CYP2D6-inhibiting drugs can affect metabolism of selected opioids; see page 18 sidebar.

§ Step therapy required: SelectHealth requires that 2 other short-acting opioid medications must be tried before prescribing this medication.
### Table 5. Long-Acting Opioid Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initial Dose</th>
<th>Max. Dose*</th>
<th>SH Tier, Cost†</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Buprenorphine transdermal system (Butrans)     | 5 mcg/hr; new application every 7 days | 20 mcg/hr; new patch every 7 days | Tier 3, $$$$$, No generic avail. Step therapy required ‡ | • May be used in opioid naïve patients at initial dose of 5 mcg/hr.  
• Buprenorphine conversion has the potential to precipitate withdrawal in patients who are already on opioids. Before conversion, taper total daily dose for up to 7 days to no more than 30 mg per day morphine (or equianalgesic dose; see page 22).  
• Doses exceeding the maximum of 20 mcg/hr have shown QT prolongation in clinical trials.  
• Titration: Should occur on an individualized basis. Wait at least 3 days before increasing dose of buprenorphine.  
• Application: If adhesion is an issue, patch edges may be taped with first aid tape. Avoid external heat sources on application site. |
| Fentanyl transdermal system (Duragesic)         | 12–25 mcg/hr; new application every 72 hours | 50 mcg/hr; new patch every 72 hrs | Tier 1, $$$ | • Special populations. Use with caution in elderly or frail patients; avoid or reduce dose unless patient is already taking >135 mg morphine equivalent. Use caution in hepatic or renal dysfunction. Reduce dose and monitor for adverse effects in patients with fever. Helpful for patients prone to constipation, with GI absorption problems, or intestinal resection.  
• Use only in opioid-tolerant patients who have been taking > 60 mg/day morphine (or equianalgesic dose) for at least 1 week.  
• Titration: Base increments on supplemental opioid doses with ratio of 25 mcg/hr Fentanyl for every 90 mg/day of morphine equivalent. Wait at least 3 days after starting dose, then increase no more often than every 6 days. Half-life continues 17 hrs after removal; steady-state is reached after several 72-hour applications.  
• Application site: Avoid external heat sources on application site. Using tegaderm over the patch helps it stay on. |
| Hydromorphone ER (Exalgo)                      | 8 to 64 mg every 24 hours, depending on prior opioid analgesics | 64 mg/day | Tier 3, $$$$$, No generic avail. Step therapy required ‡ | • For opioid-tolerant patients only, after discontinuation of all other extended-release opioids.  
• Special populations. Reduce initial dose in elderly/frail patients and in hepatic dysfunction. Reduce dose in renal dysfunction.  
• Titration: Titrate every 3 to 4 days as needed. |
| Methadone                                       | See page 23  | See page 23 | Tier 1, $ | • Special populations. Use caution with elderly or debilitated patients; reduce dosage and consider impatient monitoring during initial titration. Avoid in patients with cardiac conditions and/or patients using medications that can prolong QT interval. Avoid in patients with sleep-disordered breathing.  
• Mismatch of long half-life (~30 hours) with shorter duration of analgesia can be life-threatening. Methadone should only be prescribed by experienced clinicians who are familiar with its risks and appropriate use, and who are prepared to conduct the necessary and careful monitoring.† |

*Maximum dose:* Based on consensus (see page 18 sidebar); ensure accurate diagnosis and carefully weigh benefits (pain relief and function) against risk of increased dosage. If unclear, consult a specialist.

†Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $ = $1 to $25; $ = $26 to $75; $$$ = $76 to $150; $$$$$ = $150 to $300; $$$$$$ = $300 and up. Generic used for tier and price comparisons unless otherwise noted.

‡ Step therapy required: SelectHealth requires step therapy for this medication. (For Butrans, Embeda, Exalgo, Kadian, Opana ER, and Oxycontin CR and ER, two other long-acting opioids must be tried first. For Avinza, one other long-acting opioid must be tried first.)
TABLE 5. LONG-ACTING opioid medications, continued

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initial Dose</th>
<th>Max. Dose*</th>
<th>SH Tier, Cost†</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CR (MS Contin)</td>
<td>10 to 30 mg; duration varies by product</td>
<td>120 mg/day</td>
<td>MS Contin CR: Tier 1, $</td>
<td>Special populations. Use caution and reduce dosage with elderly or debilitated patients. Consider reducing dose or extending dosing interval by 1.5 to 2 times in hepatic dysfunction. Avoid or reduce dose in renal dysfunction; active metabolites may accumulate in patients with renal impairment and lead to neurotoxicity, hyperalgesia, allodynia, and myoclonus.</td>
</tr>
<tr>
<td>• ER (Avinza, Kadian)</td>
<td></td>
<td></td>
<td>Avinza: Tier 2, $$$$</td>
<td></td>
</tr>
<tr>
<td>• with naltrexone core (Embeda)</td>
<td></td>
<td></td>
<td>Embeda, Kadian: Tier 3, $$$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Step therapy‡ and no generic available for Avinza, Kadian, Embeda</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Special populations. Use caution and reduce dosage with elderly or debilitated patients. Consider reducing dose or extending dosing interval by 1.5 to 2 times in hepatic dysfunction. Avoid or reduce dose in renal dysfunction; active metabolites may accumulate in patients with renal impairment and lead to neurotoxicity, hyperalgesia, allodynia, and myoclonus.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>† Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $= $1 to $25; $26 to $75; $76 to $150; $150 to $300; $300+ = &gt;$300 Generic used for tier and price comparisons unless otherwise noted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>‡ Step therapy required: SelectHealth requires step therapy for this medication. (For Butrans, Embeda, Exalgo, Kadian, Opana ER, and Oxycontin CR and ER, two other long-acting opioids must be tried first. For Avinza, one other long-acting opioid must be tried first.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§ CYP2D6-inhibiting drugs can affect metabolism of selected opioids; see page 18 sidebar.</td>
<td></td>
</tr>
<tr>
<td>Oxycodeone</td>
<td>10 mg / 12 hrs</td>
<td>80 mg/day</td>
<td>CR: Tier 1, $$$</td>
<td>Special populations. Reduce initial dose by 50% in elderly/frail patients. Use caution and reduce dose by 50% in renal or hepatic dysfunction.</td>
</tr>
<tr>
<td>• CR (Oxycontin CR)</td>
<td></td>
<td></td>
<td>ER (Oxycontin): Tier 3, $$$, No generic avail.</td>
<td>† Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $= $1 to $25; $26 to $75; $76 to $150; $150 to $300; $300+ = &gt;$300 Generic used for tier and price comparisons unless otherwise noted.</td>
</tr>
<tr>
<td>• ER (Oxycontin ER)</td>
<td></td>
<td></td>
<td>Step therapy‡ for both CR and ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* Special populations. Use caution and reduce dosage with elderly/frail patients. Use caution and reduce dose by 50% in renal or hepatic dysfunction.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>† Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $= $1 to $25; $26 to $75; $76 to $150; $150 to $300; $300+ = &gt;$300 Generic used for tier and price comparisons unless otherwise noted.</td>
<td></td>
</tr>
<tr>
<td>Oxyproxone (Opana ER)</td>
<td>5 mg / 12 hrs</td>
<td>40 mg/day</td>
<td>Opana: Tier 3, $$$, No generic avail.</td>
<td>Use extreme caution in prescribing due to potential fatal interaction with alcohol.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Step therapy‡</td>
<td>Special populations. Use caution and reduce dosage with elderly patients. Avoid in hepatic dysfunction. Use caution and titrate slowly while monitoring side effects in renal dysfunction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>† Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $= $1 to $25; $26 to $75; $76 to $150; $150 to $300; $300+ = &gt;$300 Generic used for tier and price comparisons unless otherwise noted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>‡ Step therapy required: SelectHealth requires step therapy for this medication. (For Butrans, Embeda, Exalgo, Kadian, Opana ER, and Oxycontin CR and ER, two other long-acting opioids must be tried first. For Avinza, one other long-acting opioid must be tried first.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>§ CYP2D6-inhibiting drugs can affect metabolism of selected opioids; see page 18 sidebar.</td>
<td></td>
</tr>
<tr>
<td>Tramadol ER</td>
<td>100 mg / 24 hrs</td>
<td>300 mg/day</td>
<td>Tier 1, $$</td>
<td>Special populations. Start at low end of dosing range and use the lowest effective dose in elderly patients. NOT recommended in hepatic or renal dysfunction.</td>
</tr>
<tr>
<td>(Ultram ER)</td>
<td></td>
<td></td>
<td></td>
<td>* Special populations. Start at low end of dosing range and use the lowest effective dose in elderly patients. NOT recommended in hepatic or renal dysfunction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>† Tier and cost info: Tier 1 = $5-10 copay; Tier 2 = $30-35 copay; Tier 3 = $50-60 copay (based on typical SelectHealth RxSelect 2010 benefit design; some benefit designs may differ). Estimated monthly cost is based on usual dose. $= $1 to $25; $26 to $75; $76 to $150; $150 to $300; $300+ = &gt;$300 Generic used for tier and price comparisons unless otherwise noted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>‡ Step therapy required: SelectHealth requires step therapy for this medication. (For Butrans, Embeda, Exalgo, Kadian, Opana ER, and Oxycontin CR and ER, two other long-acting opioids must be tried first. For Avinza, one other long-acting opioid must be tried first.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>§ CYP2D6-inhibiting drugs can affect metabolism of selected opioids; see page 18 sidebar.</td>
</tr>
</tbody>
</table>
Opioid rotation

Rotation between opioid medications may make therapy more effective; for some patients, it may help reduce dose escalation. Rotation may also be a way to address medication-specific side effects.

When rotating a patient on opioid therapy from one medication to another, use the equianalgesic dose to plan the dosage of the new medication. The equianalgesic dose is the opioid dose that produces an equal degree of analgesia. Morphine sulfate is usually the standard reference by which all other opioid analgesics are compared. To identify the dose of the new medication and plan the transition:

1. **Calculate the patient’s current 24-hour opioid dose** (including both short- and long-acting medications).

2. **Convert the dose to its morphine equivalent**, using the table below. Then use the morphine equivalent to estimate the 24-hour dose of the new medication.

3. **Determine the dosing interval** by the formulation used (short-acting vs long-acting).

4. Due to varied responses among patients, **reduce the calculated dose** of the new medication by approximately 25% to 33%.

5. Then **titrate** the new medication to the appropriate response.

### TABLE 6. Equianalgesic dose for selected opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Approximate Equianalgesic Dose (oral and transdermal)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morphine</strong> (reference)</td>
<td>100 mg per day</td>
</tr>
<tr>
<td>Codeine</td>
<td>660 mg per day (codeine is approximately 1/7 as potent as morphine)</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
<td>25 mcg per hour; new patch every 72 hours (25 mcg patch is equiv to 45 to 135 mg of oral morphine per 24 hours)</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>100 mg per day (same potency as morphine)</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>30 mg per day (hydromorphone is 4 times more potent than morphine)</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>66 mg per day (oxycodone is approximately 1.5 times more potent than morphine)</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>33 mg per day (oxymorphone is approximately 3 times more potent than morphine)</td>
</tr>
<tr>
<td>Methadone</td>
<td>See page 23 for information on dosing and titration of methadone.</td>
</tr>
</tbody>
</table>
| Buprenorphine transdermal (Butrans) | *Do NOT rotate to Butrans from doses as high as 100 mg morphine. For patients on lower doses, use this conversion:*
|                               | • <30 mg morphine/day should convert to 5 mcg/hr     |
|                               | • 30-80 mg morphine/day should convert to 10 mcg/hr |
Special considerations for methadone therapy

The pharmacokinetic and pharmacodynamic properties of methadone are complex and incompletely documented. Methadone’s long and variable half-life means that with repetitive dosing, methadone is approximately 10 times more potent than suggested by many equianalgesic tables (derived from single-dose studies). Methadone can be particularly dangerous during initiation; in more than 80% of malpractice cases for methadone-related deaths, death occurred within the first 5 days of ingesting a new dosage.

Methadone should be prescribed only with careful precautions and monitoring by clinicians familiar with its risks. Consider a pain specialist consult, and see the general guidelines below:

- **Methadone is not appropriate** for PRN use, for breakthrough pain, or for patients with a variety of risk factors (see the table below).
- **Methadone is an option** for patients who do NOT have risk factors and who:
  - Are on high doses of another opioid, with induced morphine intolerance or opioid-induced hyperalgesia
  - Are allergic to other opioids or are taking a CYP2D6 enzyme inhibitor that could affect clearance of certain opioids (see page 18)

**TABLE 7. Risk factors and precautions for methadone**

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Notes and Precautions$^3$</th>
</tr>
</thead>
</table>
| **Torsade de pointes (TdP), a potentially fatal ventricular arrhythmia** | • Risk is increased in patients with a history of CHF or arrhythmia, or who are taking other QTc-prolonging meds or high methadone doses. Other risk factors include electrolyte imbalance, liver pathology, unexplained syncope or seizures.  
  • Precautions: Get history of arrhythmia, syncope, or heart disease. For patients at risk:
  - Get pre-treatment ECG. If QTc interval is >500 ms, avoid methadone.  
  - Get follow-up ECG within 30 days, annually, and if syncope or seizures occur. |
| **Respiratory depression and/or arrest** | • Risk is increased in patients with sleep apnea, elderly or medically compromised patients; patients with substance abuse, liver pathology, or pulmonary pathology; opioid-naïve patients, or with rapid titration or high doses.  
  • Precautions:
  - Screen for sleep apnea and avoid methadone if it is present.  
  - If other risk factors are present, avoid methadone or significantly lower the dose.  
  - Avoid benzodiazepines and other CNS depressants. |
| **Problems in elderly or frail patients** | Precautions: Lower dosage and slower titration is recommended. Frequent monitoring by healthcare professionals, family, or friends is recommended — at least daily when initiating or increasing the dose. |
| **Medication interactions** | Precautions: Monitor for changes in analgesia, serum increases, or adverse effects if the following medications are started OR stopped: tricyclic antidepressants, SSRIs, anticonvulsants, ketoconazole (Nizoral), fluconazole (Diflucan), clarithromycin (Biaxin), rifampin (Rifadin). These medications affect hepatic enzymes that metabolize methadone (CYP3A4, CYP1A2, CYP2D6). |

**REASONS FOR PRECAUTION**

In 2006, the Utah Medical Examiner concluded in 2006 that methadone caused or contributed to more accidental deaths than any other drug. Methadone accounted for a disproportionate number of deaths, particularly compared to its frequency of use.

**DOSSING AND TITRATION**

Many equianalgesic tables don’t account for methadone’s long half-life and repeated dosing, and are not accurate. Rather than using a conversion table, consider the directions below, based on the expert consensus of the chronic pain development team:

1. Regardless of the dosage of the previous opioid, begin with a methadone starting dose of 2.5 mg to 5 mg, 2 to 3 times per day. (Reduce dose for elderly or frail patients to 1 to 2 mg.)
2. Reduce the original opioid by 30-35% before the first methadone dose. Gradually cross-taper the original opioid as methadone is increased. Make short-acting medication available for breakthrough pain, and warn patients NOT to take additional methadone for breakthrough pain.
3. Titrate the methadone dose by 20-33%, no more frequently than weekly, at face-to-face visits.
4. Educate the family to watch for sedation and respiratory depression, and call 911 and go to ED for reversal agent. If no family is involved, consider following up in 1 to 2 days after any dose adjustment, or schedule phone appointments that (if missed) can trigger a safety check or EMS. See “Enhanced Monitoring” below.

**ENHANCED MONITORING**

- Assess the patient every 1 to 2 days when methadone is initiated or the dose is increased.
- Warn patients and co-inhabitants about potential drowsiness and respiratory depression.
- Educate the spouse or significant other on how to monitor for toxicity.
- The spouse or significant other should be available to check patients at least twice daily and call physician for advice if problems occur.
- Utah state guidelines recommend that the physician be available 24 hours per day during titration of methadone.
Minimizing your liability risk while prescribing opioids

Addiction risk and the legal issues surrounding opioids mean that prescribing chronic opioid therapy can make you uniquely vulnerable to prosecution or other legal problems if not managed correctly. See the information below from Intermountain Legal Counsel, focused on helping you protect yourself legally:

- **Always do a thorough physical exam and history, and document it.** Having a complete medical record can remove ambiguities or confusion around treatment.

- **Check the DOPL Controlled Substances Database for all patients and prospective patients (see page 13).** If you are prescribing opioids over a prolonged period, check the database regularly.

- **Take action if the DOPL record shows the patient is “doctor-shopping.”** Your response should depend on your training, your relationship with the patient, and the extent of the problem based on a thorough assessment:
  - If you’re comfortable working with the patient to resolve the situation, consider smaller prescriptions and more frequent visits with screening and/or pill counts.
  - If you are not comfortable working with the patient to resolve the situation, refer the patient to a pain specialist or addiction specialist for an evaluation.
  - If you aren’t comfortable treating the patient after taking the steps above, you may need to dismiss the patient from your practice.

- **Seek legal counsel if you suspect diversion/distribution.** See page 26 for more information on responding to potential diversion or distribution.

- **Ask for verification of identity if you are contacted** by law enforcement, health oversight agencies (such as the DEA or DOPL), or the state insurance fraud division for information about a patient’s medication prescriptions. **IMPORTANT:** If you are contacted by anyone other than the officials listed above, you are not allowed to provide or discuss any patient information.

- **Strictly follow the process below** if you are asked by one of the above agencies to fill out a questionnaire about your relationship with a patient and whether you were aware that they may have been receiving prescriptions from other providers:
  - **Review the DOPL Controlled Substance Database** to determine whether there have been prescriptions from multiple providers during the time that you were providing prescriptions.
  - **If the DOPL report is negative,** explain to the investigator that due to the nature of privacy laws, you are not able to discuss this topic or complete the questionnaire without a court order. Refer the person to legal counsel. Intermountain-employed physicians can contact Intermountain counsel; see the sidebar.
  - **If the DOPL database is positive** for prescriptions from multiple providers, you are permitted to fill out the questionnaire. You may want to contact legal counsel for guidance, especially if you feel you are being investigated rather than the patient.

### SPECIAL PRIVACY RULES FOR ADDICTION TREATMENT

**Federal Drug and Alcohol Confidentiality Regulations (42 CFR Part 2)** define tighter limits for clinicians who provide any type of addiction treatment.

The regulations are complex and do not apply to most primary care providers. However, if you are licensed to prescribe Suboxone for addiction treatment, you are covered by this legislation, which prohibits disclosing patient information without specific written consent; general consent forms do not apply. (Certain exceptions are also outlined by 42 CFR Part 2.)

If you are covered by 42 CFR Part 2 and you are contacted by the police or given a subpoena, seek legal counsel. (Intermountain-employed physicians can call Intermountain Legal Counsel.)

### CONTACTING INTERMOUNTAIN LEGAL COUNSEL

If you suspect a patient is diverting or distributing a controlled substance, seek legal counsel for help in evaluating the situation and deciding what to do. Intermountain-employed physicians can contact Intermountain Legal Counsel:

- Call 801-442-3519 to contact Intermountain Legal Counsel directly.
- Call the Intermountain Compliance Hotline (800-442-4845) and ask to speak with Intermountain Legal Counsel.
**Tapering opioids**

When weaning a patient from opioids by tapering the dose, consider the guidelines below. These are adapted from clinical guidelines on opioid therapy published the Utah State Department of Health⁴ and the Veteran’s Administration/Department of Defense⁵, based on expert consensus:

- **Evaluation and education.** Consider evaluating (or re-evaluating) comorbidities, the patient’s psychological condition, and other relevant factors before beginning the taper. Educate the patient and family about the taper protocol.

- **Tapering schedule.** To minimize physiological adverse effects, consider a decrease of 10% to 25% of the original dose per week. Individualize this schedule based on patient needs and symptoms. Some patients may tolerate a faster taper, while others may need to slower the dose adjustments to monthly rather than weekly.

- **Managing opioid abstinence syndrome.** If symptoms (nausea, diarrhea, muscle pain, and/or myoclonus) occur, they are unpleasant but rarely medically serious. Non-opioid analgesics and adjuvant agents can help manage irritability or pain. Use benzodiazepines cautiously, and primarily to aid in sleep.

- **Behavioral issues.** During an opioid taper, if a patient places great value on the opioid, he or she may use interpersonal strategies to delay or derail the taper, such as guilt provocation, exaggeration of suffering, or threats. Managing symptoms, educating the patient, and a referral for support may be helpful.

- **Referral.** Referral for counseling or other support during the taper is recommended if there are significant behavioral issues. For complicated withdrawal symptoms, refer the patient to a pain specialist or chemical dependency center.

▶ **MANAGING ABUSE, ADDICTION, AND DIVERSION**

Prescription pain medication addiction, abuse, and diversion have increased dramatically in the past two decades. In the U.S. in 2009, nonmedical use of pain relievers was a leading form of drug abuse for people aged 12 or older, second only to marijuana.³⁸

**Responding to potential addiction or abuse**

If you see signs of opioid addiction or abuse (see sidebar at right), it’s vital to discuss this issue with the patient, and do it in a way that preserves the patient/physician alliance. The perceived stigma associated with chronic pain and medication abuse can make this difficult. Depending on the situation, there are a variety of options for managing the situation. See the suggestions below:

- **Screen everyone.** Screen everyone for addiction or abuse (not just patients with obvious symptoms or predisposing factors). This can reduce the risk of missing early-stage problems. Letting patients know that you screen everyone can help avoid the perceived stigma of being screened. Screening options include the SOAPP-R or COMM questionnaire, the DOPL Controlled Substance Database, and urine drug tests (see page 9). Screening frequency depends on the patient and situation.

- **Affirm the patient’s privacy.** For example, “To keep you safe and decide on the best treatment, I need you to be honest about any alcohol or drug use in your life. Anything you say will be kept confidential, and used only to plan treatment.”

**WHEN IS IT ADDICTION?**

It is important to distinguish addiction from other conditions that can occur in the context of long-term opioid therapy. See the following definitions, established by the American Academy of Pain Medicine, American Pain Society, and the American Society of Addiction Medicine²⁹:

- **Addiction** is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following:
  - Impaired control over drug use
  - Compulsive use
  - Continued use despite harm
  - Craving

- **Physical dependence** is a state of being manifested by a withdrawal syndrome specific to a drug class; it can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

- **Tolerance** is the body’s physical adaptation to a drug: greater amounts are required over time to achieve the initial effect as the body “gets used to” and adapts to the intake.

- **Pseudo-addiction** is a term sometimes used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may “clock watch,” and may otherwise seem inappropriately “drug seeking.” Even such behaviors as illicit drug use and deception can occur in the patient’s efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

To screen for addiction, use the CAGE-AID questions (see page 5). To confirm addiction, consider a referral or consult with an addiction specialist.
PRESENTING CONCERNS TO PATIENTS: EXAMPLE LANGUAGE

See the example statements below that can start a conversation about potential abuse or addiction, depending on the signs that concern you:

- “We agreed I would be the only one to prescribe your pain medication, but the records show you’re also getting pain medication prescriptions from another doctor.”
- “Your urine test results don’t seem to agree with the pain medication prescribed. Can you help me understand why this may be?”
- “I’m concerned you might be developing a dangerous pattern in the way you’re using your pain medication. Can we talk about this?”

• **Present concerns in a direct way, avoiding judgment.** Being direct with patients about opioid dependence reinforces that it is a medical, not a moral, condition. (See example statements in the sidebar.)

• **Use language that prompts conversation.** Techniques include:
  - Inviting elaboration. “Tell me more about that.”
  - Asking open-ended questions. “How is the pain medication affecting your life?”
  - Summarizing (reflective listening). “What I hear you saying is that...”

• **Make treatment and monitoring changes.** These will differ based on your relationship with the patient, your level of experience managing patients with potential abuse or addiction, and the extent of the problem. You might do one or more of the following:
  - Write smaller prescriptions, with more frequent follow-up visits.
  - Conduct urine drug tests and/or check Utah’s Controlled Substance Database more frequently.
  - Refer the patient to an addiction specialist for further evaluation and/or treatment.
  - Taper the patient off opioids altogether (see page 25 for tapering strategies).
  - Ask the patient to bring in his/her medication and count pills to monitor usage.

• **Show empathy.** Patients often presume that if they tell their doctor about a problem with their medications, their doctor will be shocked or offended. It’s crucial to avoid judgment (including facial expressions, body language, etc.) and express empathy for the patient.

• **Affirm the relationship.** Where possible and appropriate, don’t abandon the patient. For example, “Because of what’s happened, we need to make some changes in how we treat your pain. Even so, I’ll continue to work with you to manage your pain and maintain your health.”

Responding to potential diversion or distribution

If a patient reports taking opioids but there is no medication in his or her system and/or if the Controlled Substance Database lists multiple prescribers, this might indicate the patient is seeking opioids for diversion or distribution.

• **If you suspect a patient is diverting or distributing medication,** present the evidence and consequences to the patient. For example: “I have come to believe that you may be distributing your medications. This is a crime that places the public and our children at risk.”

• **If you suspect a patient is diverting or distributing a controlled substance, take action — start by seeking legal counsel.** It is illegal to continue prescribing a controlled substance if you know a patient is distributing it to others; legal counsel can help you evaluate the evidence and choose the best course of action. Intermountain employed physicians can contact Intermountain legal counsel; see page 24 sidebar for contact information.
# RESOURCE SUMMARY

## TABLE 8. Resources for management of specific causes and types of chronic pain

<table>
<thead>
<tr>
<th>Condition</th>
<th>Available resources</th>
<th>Where to access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibromyalgia</td>
<td>Management of fibromyalgia syndrome. JAMA review, 2004.</td>
<td><a href="jama.ama-assn.org/content/292/19/2388.long">jama.ama-assn.org/content/292/19/2388.long</a></td>
</tr>
</tbody>
</table>

## TABLE 9. Intermountain resources for management of related risk factors and conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Provider resources</th>
<th>Patient resources</th>
<th>Where to access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>• Depression CPM and associated forms</td>
<td>• Depression booklet</td>
<td>Go to: <a href="intermountainphysician.org/clinicalprograms">intermountainphysician.org/clinicalprograms</a> or <a href="intermountain.net/clinicalprograms">intermountain.net/clinicalprograms</a>. Use the topic list to choose the appropriate topic page, or search for the topic in the Search field. Topic pages contain links to resources for both providers and patients.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>• Diabetes CPM and associated forms and teaching slides</td>
<td>• Living Well booklet and associated tools (carb counter, care card, food finder, meal plan etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient education fact sheets on diabetes medications</td>
<td></td>
</tr>
<tr>
<td>Overweight</td>
<td>• Obesity management CPM and associated weight management questionnaire and activity prescription</td>
<td>• Weigh to Health booklet, habit tracker, and classes</td>
<td></td>
</tr>
<tr>
<td>Sleep problems</td>
<td>• Obstructive sleep apnea CPM</td>
<td>• Patient education fact sheets on CPAP, home oximetry, obstructive sleep apnea, sleep habits, and sleep lab studies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Associated tools, including screening questionnaires and sleep lab referrals</td>
<td>• OSA screening questionnaire</td>
<td></td>
</tr>
<tr>
<td>Tobacco use</td>
<td></td>
<td>• Quitting Tobacco: Your Journey to Freedom booklet</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES FOR THIS CPM

The primary references for this CPM are listed below:


For a complete list of references used and cited within this document, go to: intermountainphysician.org/clinicalprograms or intermountain.net/clinicalprograms.

A link is provided on the Chronic Pain topic page, or you can search for “chronic pain references” in the search field.

Intermountain chronic pain resources for PROVIDERS

Available online at intermountainphysician.org/clinicalprograms and intermountain.net/clinicalprograms

Intermountain chronic pain resources for PATIENTS

Available as specified below:

Chronic pain patient education materials are linked in the Health Resources Topic Library under “C” at intermountainhealthcare.org

Patient education materials can be ordered from Intermountain’s Online Library and Print store: www.i-printstore.com

Fact Sheets: Opioid Medication for Short-Term Pain, Opioid Medication for Chronic Pain, Sleep Habits

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This document presents a model of care for most patients, based on evidence and guidelines available at the time of publication. Recommendations should be adapted to meet the needs of individual patients and situations, and should not replace clinical judgment.