2018

ARIZONA OPIOID PRESCRIBING GUIDELINES

A voluntary, consensus set of guidelines that promote patient safety and best practices if prescribing opioids for acute and chronic pain.

azhealth.gov/opioid

DISCLAIMER

This document should not be used to establish any standard of care or any deviation or variance from an accepted standard of care; nor should it be used solely to establish any health insurance coverage or determination. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation or variance from any part of this document as evidence of a breach of professional conduct, health insurance coverage policy or determination, or evidence that a deviation or variance from any part of this document demonstrates negligence, misconduct, errors or omissions, or breach of contract in the rendering of health care. These voluntary guidelines are an educational tool for providers, meant to promote informed management of Arizonans with acute and chronic pain. Clinicians should use their own independent clinical judgment and consider but not base clinical decisions solely on this document.

The following guidelines are founded on the best available evidence, national guidance, and Arizona-specific data on opioid overdoses.

SUMMARY GUIDELINES FOR THE TREATMENT OF ACUTE AND CHRONIC PAIN

There are more than two Arizonans dying every day from an opioid overdose, and the majority of deaths are due to prescription opioids. It is imperative that Arizona clinicians have prescribing practices that maintain safety for their patients and community, while also addressing their patients' pain.

The following seventeen guidelines for non-cancer, non-terminal pain are designed to provide information and assist decision-making for providers. Each patient and clinical presentation is unique, however, and these statements must not supersede medical judgment and risk-benefit analyses.

ACUTE PAIN

1	Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.
2	If opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration; reassess if pain persists beyond the anticipated duration.
3	Do not use long-acting opioids for the treatment of acute pain.

CHRONIC PAIN

4	Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.
5	Do not initiate long-term opioid therapy for most patients with chronic pain.
6	Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders and behavioral health conditions.

RISK MITIGATION

7	For patients on long-term opioid therapy, document informed consent which includes the risks of opioid use, options for alternative therapies and therapeutic boundaries.
8	Do not use long-term opioid therapy in patients with untreated substance use disorders.
9	Avoid concurrent use of opioids and benzodiazepines. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.
10	Check the Arizona Controlled Substances Prescription Monitoring Program before initiating an opioid or benzodiazepine, and then at least quarterly.
11	Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes prior to prescribing opioids to women of reproductive age.
12	If opioids are used to treat chronic pain, prescribe at the lowest possible dose and for the shortest possible time. Reassess the treatment regimen if prescribing doses ≥50 MEDs.
13	Counsel patients who are taking opioids on safety, including safe storage and disposal of medications, not driving if sedated or confused while using opioids and not sharing opioids with others.
14	Reevaluate patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors and psychiatric comorbidities through face-to-face visits, PDMP checks and urine drug tests.
15	Assess patients on long-term opioid therapy on a regular basis for opioid use disorder and offer or arrange for medication-assisted therapy (e.g. methadone and buprenorphine) to those diagnosed.
16	Offer naloxone and provide overdose education for all patients at risk for opioid overdose.
17	Individualize an exit strategy from the use of long-term opioid therapy for chronic pain, while carefully monitoring for risks.

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PURPOSE OF THE GUIDELINES

The Centers for Disease Control and Prevention (CDC) has described an opioid epidemic in the United States. Overdoses involving heroin, fentanyl and prescription opioids killed more than 33,000 people in the United States in 2015. Nearly half of those deaths were from prescription opioids.

The Arizona Department of Health Services has found that more than two Arizonans die every day from an opioid overdose, the majority from prescription opioids. Prescription opioids are used routinely in Arizona, with over 205 million opioid pills prescribed between January and July 2017, enough for every resident to have a 30-pill supply. In addition to overdose fatalities, there are many times those numbers of nonfatal opioid overdoses reported to the Department, along with daily reports of suspected neonatal abstinence syndrome.

Prescribing practices have contributed to the current opioid crisis and a shift in prescribing culture, approach to pain and recognition of substance use disorders is needed. The following *Arizona Opioid Prescribing Guidelines* aim to reduce overreliance on opioid therapy, make safety a priority in managing acute and chronic pain, and increase awareness of treatment of opioid use disorder. These guidelines reflect the best available evidence and local data, and can assist in clinical decision-making for Arizona providers. It is recognized that access to recommended options may be limited by availability and affordability.

UPDATES TO THE GUIDELINES

This is the second edition of the *Arizona Opioid Prescribing Guidelines*. One of the deliverables from the 2017 State of Public Health Emergency, as declared by Arizona Governor Doug Ducey, was to update the 2014 guidelines for Arizona clinicians. Current updates reflect:

1. Incorporation of the most recent evidence, national guidelines (including the VA/DoD *Clinical Practice Guideline for Opioid Therapy for Chronic Pain,* 2017 and CDC *Guideline for Prescribing Opioids for Chronic Pain,* 2016), best practices from other states and Arizona data. Most references are recent, and guided the inclusion of newer concepts such as “high-impact chronic pain,” “complex persistent opioid dependence” and “opioid exit strategies.”

2. A shift in pain care that avoids unnecessary exposure to opioids in order to reduce the risk of adverse outcomes. Previous guidelines focused on the “safe prescribing” of opioid therapy, while these guidelines aim to prevent initiating unnecessary opioid therapy while addressing patients’ pain from a whole-person perspective.

3. Emphasis on nonstigmatizing language. Health care providers can counter stigma by using accurate, nonjudgmental language. These guidelines employ person-first language (“Patients with substance use disorder” instead of “addicts”), nonjudgmental terminology (“negative urine drug test” instead of “dirty”) and supportive terms (“recovery” instead of “no cure”).

4. Increased focus on prevention, recognition, and treatment of opioid use disorder in patients receiving long-term opioid therapy for chronic pain, given the high risk of developing opioid use disorder in this population.

5. Integration into clinical workflow (operationalization). A key element of success of guideline implementation is how seamlessly it can be incorporated into a clinician’s normal activities. This revised version includes specific operationalization actions under each guideline, and summarizes them in *Appendix A*. The tone is also purposely direct and actionable, rather than passive.

INTENDED AUDIENCE AND SCOPE

The *Arizona Opioid Prescribing Guidelines* (2018) are intended for use by clinicians in primary care and outpatient settings who provide care to patients receiving treatment for acute and chronic pain that is not occurring at the end of life or after complex surgery, and is not due to an active malignancy.

They may also be used by hospitals, outpatient surgical centers, behavioral health inpatient facilities and nursing care institutions for the management of pain upon discharge.

GLOSSARY OF TERMS

ACUTE PAIN: pain lasting less than 90 days.

ADDICTION: a primary, chronic disease of brain reward, motivation, memory and related circuity. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. Addiction is characterized by the inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.

ARIZONA STATE BOARD OF PHARMACY CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM (AZ CSPMP): Arizona's Prescription Drug Monitoring Program.

BIOPSYCHOSOCIAL ASSESSMENT: a comprehensive assessment of co-occurring medical and psychiatric conditions, personal and family history of substance use disorder, functional status and functional goals, coping strategies, and psychosocial factors such as the patient's beliefs and expectations about chronic pain and its treatment.

CDC: Centers for Disease Control and Prevention.

CHRONIC PAIN: pain persisting longer than 3-6 months and beyond the normal tissue healing time.

COMPLEX PERSISTENT OPIOID DEPENDENCE: the clinical and psychological state that exists on the continuum between simple opioid dependence (which presents with short-lived and self-limited withdrawal symptoms after opioids are discontinued) and opioid-use disorder. Symptoms of complex persistent opioid dependence can include worsening pain, patient reported function, affective symptoms, sleep disturbance and other protracted withdrawal symptoms upon opioid dose reduction or cessation.

FDA: Food and Drug Administration.

HIGH IMPACT CHRONIC PAIN: chronic pain that is associated with substantial restriction of participation in work, social and self-care activities for six months or more.

INFORMED CONSENT: patient-centered information about known benefits and harms of treatment.

LONG-ACTING OPIOID THERAPY: opioid formulations that are Extended Release (ER) or Long Acting (LA).

LONG-TERM OPIOID THERAPY: use of opioid-medications for more than 90 days.

MEDICATION-ASSISTED TREATMENT (MAT): use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

MORPHINE EQUIVALENT DOSE (MED): the equipotent dose of an opioid expressed as the equivalent dose of oral morphine.

NALOXONE: medication approved by the Food and Drug Administration (FDA) to reverse an overdose by opioids by blocking opioid receptor sites, reversing the toxic effects of the overdose.

NEONATAL ABSTINENCE SYNDROME: a group of conditions caused when a baby withdraws from certain drugs from intrauterine exposure, often caused by opioids.

OPIOID THERAPY: the use of opioid medications to treat pain.

OPIOID USE ABERRANT BEHAVIORS: a set of behaviors suggestive of problematic prescription opioid use, including aggressively requesting medications, reports of lost or stolen prescriptions, decreasing functionality or frequent accidents while using opioids, repeat noncompliance, unsanctioned dose escalations, early refill requests, obtaining opioids from multiples sources and use of non-prescribed drugs.

OPIOID USE DISORDER: a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two DSM-5 criteria occurring within a 12-month period (full criteria listed in *Appendix C*).

SUBSTANCE USE DISORDER: a disorder that includes a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. The diagnosis is based on a pathological pattern of behaviors related to use of the substance. The diagnostic criteria can be considered to fit within the following groupings: impaired control, social impairment, risky use and pharmacological criteria.

URINE DRUG TESTING: testing of urine for various drugs and metabolites using screening and confirmatory tests to provide documentation of adherence to an opioid treatment plan and aid in the diagnosis and treatment of addiction or substance use disorders. Knowledge of the sensitivities and specificities for each test is critical to accurate interpretation.

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ELABORATED GUIDELINES FOR THE TREATMENT OF ACUTE AND CHRONIC PAIN

ARIZONA DEPARTMENT
OF HEALTH SERVICES

ELABORATED GUIDELINES FOR THE TREATMENT OF ACUTE PAIN

1 Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.

Patients should receive treatment for pain that provides the greatest benefits relative to risks. There is evidence that acute pain can be ameliorated by non-pharmacologic and non-opioid therapies, including psychological therapies, exercise treatments (aerobic exercise, physical therapy) and NSAIDs.[1 2 3 4 5 6] Due to their low harm, these therapies should be offered to all patients with mild or moderate pain. Opioids should only be initiated after weighing the benefits against the risks of use. Long-term opioid use can result from opioids initially intended for short-term use,[7 8 9] and both acute and long-term opioid use run the risk of opioid overdose. [9 10] Realistic expectations regarding duration and severity of expected pain should be provided to patients.

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2 If opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration; reassess if pain persists beyond the anticipated duration.

Because there is no absolute safe dose of opioids, opioid therapy should be initiated at the lowest effective dose and for the shortest possible duration. Evidence shows that the longer duration of early opioid exposure is associated with greater risks for long-term use.[11] There is also a risk of opioid-related adverse events even during acute, short-term therapy.[12]

The recommendation for a short duration of opioid therapy for acute pain is supported by recent evidence, which suggests that each additional day of opioid use beyond 3 days increases the likelihood of an adverse event or long-term use.[11] Each day of unnecessary opioid use increases the likelihood of physical dependence without adding benefit.[13] Prescriptions with fewer days' supply will also minimize the number of pills available for nonmedical use or diversion.

Clinicians should reevaluate patients with severe acute pain that continues longer than expected before continuing opioid therapy. Patients who do not experience clinically meaningful pain relief early in treatment are unlikely to experience pain relief with long-term use,[14] and revisions to the initial diagnosis and management plan may be necessary. In addition, the risk of acute opioid therapy extending into long-term opioid therapy is increased in patients who refill the initial prescription.[11]

A note about a particular opioid, tramadol: tramadol has two known mechanisms of analgesia – it is a weak μ-opioid receptor agonist and it inhibits the reuptake of norepinephrine and serotonin. Use of tramadol is a risk factor for continued opioid use: more than 64% of patients started on tramadol for acute pain remain on tramadol after one year.[11] Emergency department visits associated with tramadol-related adverse effects have also increased by 145% from 2005-2011.[15] There are increased adverse effects when tramadol is combined with benzodiazepines, opioid pain medications and/or alcohol. Coadministration of tramadol with agents that increase serotonergic activity can precipitate serotonin syndrome and caution should be used with this combination.

A note about post-surgical indications: this guideline may apply to the treatment of postoperative pain from low-risk surgical procedures. A 2017 systematic review found that postoperative prescription opioids often go unused, unlocked and undisposed.[16] More than two-thirds of patients reported unused prescription opioids following surgery, consists across several studies of general, orthopedic, thoracic, and obstetric inpatient and outpatient surgeries.[16]

DO IT Change the default duration for electronic opioid prescriptions to 3- or 5- days.

- See *Appendix F, How to manage pain and opioids in special populations* for further details on post-surgical opioid use.
- See *Appendix G, How to connect with local and national resources* for Arizona Data from Enhanced Surveillance, showing that 60% of persons with a suspected opioid overdose had a prescription written for six or more days.

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3 Do not use long-acting opioids for the treatment of acute pain.

Multiple national agencies, including the Veterans Administration and Centers for Disease Control and Prevention, recommend against using long-acting opioids for the treatment of acute pain. There is a higher risk for overdose among patients who initiate treatment with extended-release/long-acting opioids than among those who initiate with immediate-release opioids.[17] Further, long-acting opioids are associated with an increased risk of all-cause mortality.[18]

4 Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.

Self-management approaches should be recommended to all patients with chronic pain. Self-management refers to management of the pain, its symptoms, and of one's relationship with the symptoms. (Evidence shows self-management approaches improve self-efficacy in multiple chronic conditions[19 20 21] and that opioid treatment of chronic pain may undermine self-care.[22])

Many non-pharmacological therapies, including physical therapy, weight loss, psychological therapies (e.g. cognitive behavioral therapy) and multidisciplinary rehabilitation can ameliorate pain and function.[13 23 24 25 26] Spinal manipulation, massage and acupuncture may be helpful in some chronic pain conditions.[27 28 29]

Non-opioid pharmaceuticals (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) may also be helpful for a variety of chronic pain conditions.[30 31 32 33 34 35 36 37 38 39 40 41]

Due to the favorable benefit-to-risk profile, these noninvasive, non-opioid therapies are preferred and should be offered to all patients with chronic pain. There is a lack of evidence showing any sustained functional benefit of long-term opioid therapy for chronic pain, but there is evidence of dose- and duration-dependent harms (see *Guideline #5*).

DO IT Create acute and chronic pain order sets that include non-pharmacologic treatment, non-opioid treatment and common referral sources (such as physical therapy, psychotherapy, substance use treatment, addiction specialists, pain medicine specialists, etc.).

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5 Do not initiate long-term opioid therapy for most patients with chronic pain.

While benefits for pain relief, function and quality of life with long-term opioid use for chronic pain are uncertain, risks associated with long-term opioid use are significant and increase with increasing dose and duration of opioid use.[12 42 43] Risks to patients include overdose, overdose death, addiction, depression, opioid induced hypogonadism, opioid-induced hyperalgesia, and worsening function.[18 44 45 46 47 48 49 50 51 52 53] A 2017 Cochrane Review found good-quality evidence that use of opioids for greater than two weeks is associated with a significantly increased risk of experiencing an adverse event when compared to use of a placebo and non-opioid pharmacotherapy, and identified a very high absolute rate (78%) for adverse events.[54] Due to this unfavorable balance of risks compared to benefits, initiating opioid therapy for common causes of chronic pain including low back pain, osteoarthritis pain, fibromyalgia, neuropathy and headache is not recommended. The decision to initiate opioid therapy must be made on a case-by-case basis after carefully weighing the known risks against possible benefits.

DO IT Develop a system for opioid stewardship, i.e. monitoring opioid prescribing practices, outcomes and provider alignment with guidelines and best available evidence.

- See *References, Veterans' Administration 2017 Clinical Practice Guideline for Opioid Therapy*, "Recommendation 1) We recommend against initiation of long-term opioid therapy for chronic pain."

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6 Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders and behavioral health conditions.

There is an increased risk of poor outcomes including opioid overdose, opioid use disorder and death, for patients taking opioids that have substance use disorders or behavioral health conditions.[7 8 55 56 57] These clinical situations can be challenging to manage, and are further complicated by the possibility of providers inadvertently exposing the patient to dangerous drug-drug interactions. Interdisciplinary care for patients is advised, even as more research is needed on efficacy and feasibility of arranging such care.

The key disciplines that benefit patients with higher complexity chronic pain include primary care, substance use specialties, pain medicine, mental health, dietitians, health coaching and movement specialties (e.g. physical therapy). If interdisciplinary care is not available in a single care setting, it should be coordinated virtually between distinct care sites.

DO IT Use available case management resources, which may be offered by facilities, insurance companies, accountable care organizations or other local resources.

RISK MITIGATION

7 For patients on long-term opioid therapy, document informed consent which includes the risks of opioid use, options for alternative therapies and therapeutic boundaries.

The degree of risk associated with long-term opioid therapy *(see Guideline #5)* warrants completion of informed consent, to ensure and document patient and provider understanding of the risks and benefits of opioid therapy. Informed consent should be obtained prior to initiation and following any changes to the treatment plan.

A risk stratification should be performed as part of a risk/benefit assessment prior to initiating or continuing opioid therapy in patients with chronic pain. Risk assessment can be accomplished either by using existing opioid risk assessment tools such as the Opioid Risk Tool or the Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R). There are known limitations of risk tools, including low-sensitivity for the ORT and patient burden for longer tools like the SOAPP-R.

The care of patients with chronic pain should include a comprehensive medical and pain-related evaluation that includes assessing for substance use, psychiatric comorbidities and functional status. Comorbidities of anxiety and depression in particular may influence pain perception and exacerbate pain complaints.

DO IT Incorporate an informed consent document for regular clinic use.

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8 Do not use long-term opioid therapy in patients with untreated substance use disorders.

The recommendation against long-term opioid therapy for patients with substance use disorders is supported by at least five large studies and national recommendations.[8 12 43 56 57] Among patients with untreated substance use disorder, opioids carry a significant risk for adverse outcomes including opioid use disorder, opioid overdose and death. The lack of evidence of efficacy of long-term opioid therapy *(see Guideline #5)* and considerable evidence of significant harms of overdose, death and suicide outweighs any potential modest benefit of prescribing long-term opioid therapy in this population. In these patients, treatment of pain should optimize non-pharmacologic and non-opioid pharmacotherapy.

For patients already receiving long-term opioid therapy who are diagnosed with an untreated substance use disorder, clinicians should monitor closely, offer or arrange for substance use disorder treatment, and proceed with an exit strategy from the use of long-term opioid therapy for chronic pain *(see Guideline #17).*

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9 Avoid concurrent use of opioids and benzodiazepines. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.

Concurrent use of opioids and benzodiazepines is associated with an increased risk of overdose and death and there is a FDA Black Box Warning, the FDA's strongest warning, against it.[58] Both agents cause central nervous system depression and can decrease respiratory drive, and their combined use is associated with a 4-10 fold increased risk of opioid overdose death.[59 60 61 62] The greatest risk is associated with the use of higher doses of opioids.[63]

Particular caution should be exercised when opioids are used with other sedatives/hypnotics.[56] Data from the Arizona Enhanced Surveillance showed that 17% of reported fatal overdoses had a sedative-hypnotic along with the opioid, versus 8% of reported nonfatal overdoses.

Many patients with chronic pain have other psychological comorbidities.[64] It is important to note that there is a lack of evidence of efficacy for benzodiazepines in the management of PTSD or chronic anxiety. The 2017 *Veterans Administration/ Department of Defense Clinical Practice Guideline for Post-Traumatic Stress Disorder and Acute Stress Disorder* provides a strong recommendation against the use of benzodiazepines for the treatment of PTSD due to lack of evidence of benefit and their association with known adverse events.[65] It is also important to coordinate a patient's care with other providers and check the AZ CSPMP to determine if patients are receiving a benzodiazepine or other drug capable of inducing fatal drug-drug interactions, such as fentanyl with CYP3A4 inhibitors and drugs that can prolong the QT interval.

Patients who are receiving concurrent opioid and benzodiazepine therapy should be assessed for exiting or tapering one or both agents, but abrupt discontinuation is not recommended. Abrupt discontinuation of benzodiazepines may be associated with serious adverse events including seizures and possible death. For high complexity patients, consider consultation with pain medicine specialists, substance use specialists and/or mental health specialists.

- See *Appendix E: How to approach opioid tapering.*
- See *Appendix G: How to connect with local and national resources,* FDA Black Box Warning, which was signed and requested by the health officials at the Arizona Department of Health Services in 2016.
- See *Appendix G: How to connect with local and national resources,* Arizona Data from Enhanced Surveillance, showing that for both fatal and non-fatal overdoses, the most common drug combination was opioids and benzodiazepines.

10 Check the Arizona Controlled Substances Prescription Monitoring Program before initiating an opioid or benzodiazepine, and then at least quarterly.

Checking the Arizona Controlled Substances Prescription Monitoring Program (AZ CSPMP) before prescribing an opioid analgesic or benzodiazepine controlled substance and at least quarterly during treatment is good medical practice and a mandate under Arizona Revised Statutes 36-2606.[66] Use of the AZ CSPMP provides objective data to assist with identification of harmful medication interactions or evidence of multiple providers prescribing controlled substances. There are exceptions to the legal mandate (including for patients receiving hospice and palliative care). Data comparing states with an implemented prescription database compared to states without one showed 1.55 fewer deaths / 100,000 people.[67]

As of the publication of these guidelines, methadone prescriptions do not appear in the AZ CSPMP. Prescribers must recognize this limitation, and methadone-prescribers are in turn encouraged to consult the AZ CSPMPs to check for patients who are being prescribed benzodiazepines by their psychiatrists or primary care physicians.

Recognizing that patients may provide inaccurate names and dates of birth, patients should be able to verify their identity when receiving an opioid prescription. This corroboration adds a safeguard against opioid misuse.

DO IT Ensure that clinicians and assigned delegates are registered and able to access the Arizona Controlled Substances Prescription Monitoring Program.

- See *Appendix G: How to connect with local and national resources,* Legislative language on AZ CSPMP.

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11 Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes prior to prescribing opioids to women of reproductive age.

There are studies that have shown an association of opioid use in pregnancy with birth defects, including neural tube defects, congenital heart defects, gastroschisis, preterm delivery, poor fetal growth, stillbirth and neonatal abstinence syndrome.[13] In 2017, the American College and Obstetrics and Gynecology and the American Society of Addiction Medicine published a Committee Opinion to avoid or minimize the use of opioids for chronic pain management and to highlight alternative pain therapies such as non-pharmacologic and non-opioid pharmacologic treatment.[68]

For women of reproductive age, contraceptive counseling and access to contraceptive services should be a routine part of substance use disorder treatment to minimize the risk of unplanned pregnancy.[68]

For pregnant women with opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal.

- See *Appendix G: How to connect with local and national resources,* ACOG/ASAM Committee Opinion #711.
- See *Appendix G: How to connect with local and national resources,* Arizona Data from Enhanced Surveillance, showing that 151 infants were born with suspected neonatal abstinence syndrome during the first 60-day period.

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12 If opioids are used to treat chronic pain, prescribe at the lowest possible dose and for the shortest possible time. Reassess the treatment regimen if prescribing doses ≥50 MEDs.

There is no absolutely safe dose of opioids.[69] Risk for opioid use disorder increases with duration and dose.[12 42 43] Risk of prescription opioid overdose and death exists even at low opioid dosage levels, and increases with prescribed dose. Opioid dosages between 50-99 MEDs have been found to increase risks for opioid overdose by factors of 1.9 to 4.6 compared with dosages < 20 MEDs, and dosages ≥100 MEDs are associated with increased risks of overdose 2.0 to 8.9 times the risk at <20 MEDs.[7 8 56 70] As such, careful documentation and decision-making must be undertaken to accurately weigh risks against benefits for high-dose opioid prescriptions. The primary goal of care for a patient with chronic pain is maximizing function and minimizing pain-related suffering, rather than elimination of pain.

For higher risk patients, consider consultation with a pain-management specialist, substance-use disorder specialist, mental health specialist or coordination of interdisciplinary care.

Of note, extended-release/long-acting opioids have not been proven to be safer or more effective than short-acting opioids for managing chronic pain. There is an association between long-acting opioid use and significantly increased risk of all-cause mortality.[18]

DO IT Develop a system for opioid stewardship, i.e. monitoring opioid prescribing practices, outcomes and provider alignment with guidelines and best available evidence.

- See *Appendix G: How to connect with local and national resources,* Arizona Data from Enhanced Surveillance, showing that the mean MEDs prescribed to persons with suspected overdoses and deaths was 96 MEDs.

13 Counsel patients who are taking opioids on safety, including safe storage and disposal of medications, not driving if sedated or confused while using opioids and not sharing opioids with others.

Some of the dangers from opioid use can extend from the patient into the public. Household members of persons in possession of opioids are themselves at increased risk of an opioid overdose.[71] Children are in danger of initiating opioids or having opioid poisoning.[72] The public is at risk from a driver that is impaired.[73] Counseling and educating patients and their families about safety is imperative, as is notifying them that sharing of controlled substances is a felony, subject to imprisonment or fines.

- See *Appendix G: How to connect with local and national resources,* DEA on Sharing of Controlled Substances.
- See *Appendix G: How to connect with local and national resources,* Safe Disposal Locations.

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14 Reevaluate patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors and psychiatric comorbidities through face-to-face visits, PDMP checks and urine drug tests.

There is a heightened risk for developing opioid use disorder in patients who take opioids for more than 90 days.[74 75] There is also a heightened risk for opioid use disorder in persons with concurrent substance use and psychiatric comorbidities.[76 77 78] Face-to-face visits should focus on function and quality of life (rather than only pain intensity), optimizing treatment for medical and psychiatric comorbidities, assessing progress towards the patient's goals and values, and routine safety monitoring with PDMP checks and urine drug testing. The use of risk mitigation strategies, including face-to-face visit, PDMP checks and urine drug testing protect both patients and providers. Beginning in October 2017, checking the PDMP is a legal mandate in Arizona.[66] While there is no clear evidence that urine drug testing improves outcomes, it can help identify patients with substance use disorders and other high-risk behaviors so that evidence-based therapy and risk mitigation strategies can be implemented. It is recognized that urine-drug screens (e.g. immunoassays) have limitations in sensitivity and specificity, and thus should be confirmed through appropriate tests (e.g. gas chromatography-mass spectrometry or high performance liquid chromatography).

DO IT Create a checklist for refill requests for long-term opioids which includes an evaluation for adverse effects, assessment for substance or opioid-use disorder, check of the CSPMP and urine drug screens and review of the management plan.

DO IT Create a registry for established patients on long-term controlled substances, and apply risk mitigation strategies as detailed in *Guidelines #7-17*.

- See *Appendix A: How to implement these guidelines into clinical flow,* providing an example registry.
- See *Appendix C: How to evaluate patients for opioid use disorder,* including diagnostic criteria and later notes on diversion.
- See *Appendix G: How to connect with local and national resources,* Legislative language on PDMP.

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15 Assess patients on long-term opioid therapy on a regular basis for opioid use disorder and offer or arrange for medication-assisted therapy (e.g. methadone and buprenorphine) to those diagnosed.

All patients using opioids are at-risk for developing an opioid use disorder.[69] There is strong evidence to support the use of opioid agonist therapy (i.e. methadone or buprenorphine) for patients with opioid use disorder.[79] Methadone-maintenance therapy for opioid use disorder is dispensed at federally-licensed opioid treatment programs whereas buprenorphine can be prescribed by DATA-2000 waivered clinicians (see *Appendix G* for Waiver Training). Opioid agonist therapy decreases opioid use, opioid-related overdose deaths, criminal activity and infectious disease transmission.[80 81 82] It increases social functioning and retention in treatment.[80 81] It also improves outcomes for the babies of opioid-dependent pregnant women.[83]

For patients with opioid use disorder, withdrawal management, otherwise known as detoxification, is less effective compared to agonist therapy and is associated with a significantly increased risk of relapse and treatment failure.[80 84 85] Withdrawal management should be used in conjunction with opioid antagonist therapy (e.g. injectable extended-release naltrexone) and/or other behavioral treatment with the understanding that attrition, mortality and return to use is higher compared to opioid agonist therapy.[86]

According to several conservative estimates, every dollar invested in addiction treatment programs provides cost savings by a ratio of 12 to 1.[87]

DO IT Become a buprenorphine-waived prescriber.

DO IT Collect and maintain substance use treatment resources that are relevant to the patient population served by the facility.

- See *Appendix C: How to evaluate and manage patients for opioid use disorder.*
- See *Appendix G: How to connect with local and national resources,* Arizona survey results for accessibility of Medication Assisted Treatment.
- See *Appendix G: How to connect with local and national resources,* Buprenorphine Waiver Training.

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16 Offer naloxone and provide overdose education to all patients and to family/significant others of patients at risk for opioid overdose.

Naloxone administration has been identified as a life-saving measure following opioid overdose. There is moderate evidence that take-home naloxone programs are effective at improving overdose survival and decreasing mortality and it is plausible that effectiveness would be observed in the clinical setting as well.[13] Distribution of naloxone for reversal is supported by Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, Veterans Administration, Department of Defense, American Medical Association and other associations.

Patients at risk for opioid overdose include those with opioid use disorder or substance use disorder, those with a higher prescribed opioid dosage, those with mental health conditions, those who use opioids in combination with other sedating substances, those who have other conditions such as HIV, liver or lung disease or suffer from depression, or household members of people in possession of opioids.[71] Still, consider offering naloxone and overdose education to all patients, regardless of recognized risk factors, on long-term opioid therapy.

DO IT Create or use standing orders for naloxone.

- See *Appendix G: How to connect with local and national resources,* Arizona Naloxone Standing Orders, making naloxone available to patients and family members at pharmacies without a prescription.
- See *Appendix G: How to connect with local and national resources,* Arizona Data from Enhanced Surveillance, showing that over 1,000 doses of naloxone were administered to suspected opioid overdoses during the first 60-day surveillance period.

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17 Individualize an exit strategy from the use of long-term opioid therapy for chronic pain, while carefully monitoring for risks.

Long-term opioid therapy is associated with known risks and unproven benefits (See *Guideline #5*). Patients with chronic pain who are prescribed long-term opioid therapy should receive an individualized treatment plan to minimize opioid-related adverse events. Treatment plans include the development of an opioid exit strategy, which transitions patients from long-term opioid therapy to a different treatment strategy and should be tailored to each patient's unique situation.

The primary exit strategies include **a)** tapering the opioid dose **b)** rotating to buprenorphine and then gradually tapering the buprenorphine dose and **c)** offering or arranging medication-assisted treatment for patients with opioid use disorder. The choice of exit strategy cannot be done casually or with a "one-size-fits-all" approach; it should be guided by a biopsychosocial assessment of the patient, including evaluation of co-occurring medical and psychiatric conditions, substance use disorders, and the patient's social support system. While there is clear evidence for the effectiveness of treating opioid use disorder with medication-assisted treatment (See *Guideline #15*), there is no established evidence to otherwise guide the best opioid exit strategy approach for an individual.

While opioid tapering seems a logical intervention for patients on long-term opioid therapy at risk for adverse events, tapering {Strategy (a)} may not be optimal for all patients. Generally, patients with lower MED prescriptions, lower pain-related dysfunction and lower psychiatric comorbidities can be candidates for a gradual taper (See *Appendix E* for tapering guidance). In contrast, consider Strategy (b) (rotation to buprenorphine and subsequent buprenorphine tapering) for patients with higher MEDs, and higher pain-related dysfunction and comorbidities. After initiating an exit strategy, ongoing biopsychosocial assessment may guide the clinician to switch to a different strategy.

Abrupt opioid discontinuation is not recommended as an exit strategy, unless required for immediate safety concerns (e.g. evidence for diversion, threatening behavior, serious disruptive behavior, suicidal ideation or behaviors).

DO IT Use available case management resources, which may be offered by facilities, insurance companies, accountable care organizations or other local resources.

- See *Appendix C: How to evaluate patients with opioid use disorder.*
- See *Appendix D: How to connect patients with medication-assisted treatment.*
- See *Appendix E: How to approach an opioid exit strategy,* which includes details on tapering and the need for ongoing risk assessments.

APPENDIX A

HOW TO IMPLEMENT THESE GUIDELINES INTO CLINICAL FLOW

ARIZONA DEPARTMENT
OF HEALTH SERVICES

APPENDIX A: HOW TO IMPLEMENT THESE GUIDELINES INTO CLINICAL FLOW

Guidelines are only as impactful as their integration into normal clinical flow. The following are examples of concrete actions that lead toward integration, and summarizes the **DO IT** actions listed under the Elaborated Guidelines for the Treatment of Acute and Chronic Pain.

There is increasing attention on opioid prescribing and practices in Arizona, with further mandates from Arizona legislature and attention from Arizona Regulatory Boards and Mortality Review Boards. This list can be passed to practice managers to closer align with best practices and legal mandates, along with providing quality assurance.

DO IT

- ☐ Ensure that clinicians and assigned delegates are registered and able to access the Arizona Controlled Substances Prescription Monitoring Program.

  Application website: *pharmacypmp.az.gov/*

- ☐ Establish a policy in your healthcare facility to not prescribe opioids to a new patient on long-term opioid therapy at the first visit, or before having prior medical records.

  Sample policy: *med.umich.edu/1info/FHP/practiceguides/pain/policy.pdf*

- ☐ Create acute and chronic pain order sets that include non-pharmacologic treatment, non-opioid treatment and common referrals (such as physical therapy, psychotherapy, substance use treatment, addiction specialists, pain medicine specialists, etc.)

- ☐ Incorporate an informed consent document for regular clinic use.

  Sample consent: *drugabuse.gov/sites/default/files/files/SampleInformedConsentForm.pdf*

- ☐ Change the default duration for electronic opioid prescriptions to 3- or 5- days.

  Example sig: *Oxycodone 5mg tablet, Take 1 tablet PO Q6hrs PRN fracture pain x 3 days, Disp #12, Refills 0.*

- ☐ Become a buprenorphine-waived prescriber.

  Application website: *samhsa.gov/medication-assisted-treatment*

- ☐ Create a checklist for refill requests for long-term opioids which includes an evaluation for adverse effects, assessment for substance or opioid-use disorder, check of the CSPMP and urine drug screens, and review of the management plan.

  Sample checklist: *cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf*

- ☐ Create or use standing orders for naloxone.

  Sample standing orders: *nchrc.org/assets/NCHRC-Standing-Orders-Expire-2018.pdf*
  ADHS standing orders: *azdhs.gov/naloxone-standing-order*

- ☐ Collect and maintain substance use treatment resources that are relevant to the patient population served by the facility.

  SAMHSA treatment locator: *samhsa.gov/find-help*

- ☐ Use available case management resources, which may be offered by facilities, insurance companies, accountable care organizations or other local resources.

- ☐ Create a registry for established patients on long-term controlled substances, and apply risk mitigation strategies.

- ☐ Develop a system for opioid stewardship, i.e. monitoring opioid prescribing practices, outcomes and provider alignment with guidelines and best available evidence.

APPENDIX B

HOW TO MANAGE AN "INHERITED PATIENT ON OPIOIDS"

ARIZONA DEPARTMENT
OF HEALTH SERVICES

APPENDIX B: HOW TO MANAGE AN "INHERITED PATIENT ON OPIOIDS"

Establishing care of new patients on long-term opioid therapy can be difficult, but is an opportunity to optimize the treatment approach. The following is a guide to how to approach these situations, based upon the following underlying concepts:

- Safety is always more important than immediate pain relief.
- Care of the patient's pain and distress is imperative; care does not necessarily include opioids.
- Assessment and management of substance use disorders is important.
- Opioid withdrawal can be very uncomfortable and distressing, but is rarely a medical emergency.
- Opioid withdrawal can be effectively managed with both pharmacologic and non-pharmacologic approaches.

BEFORE THE VISIT

- Consider establishing a clinic policy that a patient's first visit will serve as an assessment, which includes review of prior medical records and patient examination and does not involve prescribing of controlled substances.
- Contact new patients prior to their first visit to review clinic policies and what to expect at their first clinical visit, including the request to bring in all previous medical records and current medications.
- Verify that clinical providers and staff representatives have access to the Arizona Controlled Substances Prescription Monitoring Program.
  - CSPMP application: *arizona.pmpaware.net/login*
- Consider becoming a medication assisted treatment provider, to broaden the therapeutic options for patients at their primary facility.
  - See Buprenorphine Waiver Training: *samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training*

DURING THE INITIAL VISIT

- Complete a comprehensive Biopsychosocial Assessment of the patient.
  - Elements of the biopsychosocial pain interview include a pain-related history, assessment of pertinent medical and psychiatric comorbidities including personal and family history of substance use disorder, functional status and functional goals, coping strategies, and psychosocial factors such as the patient's beliefs and expectations about chronic pain and its treatment. This includes an evaluation of medical, psychiatric, and co-occurring substance use conditions, and the patient's social support system.
- Review prior medical records and request consent to speak with prior prescriber.
- Check the AZ CSPMP record for the patient after verifying his or her identification.
- Obtain a baseline urine drug screen.
- Explain to the patient that more information may be needed before determining an optimal treatment regimen, and explain the risks and benefits of individual or combinations of drugs.
- Introduce current best practices for treating chronic pain, including emphasis on self-management, non-pharmacologic, and non-opioid pharmacotherapy, setting functional treatment goals and prioritizing safe and sustainable treatment plans.
- **Based on the information gathered above, determine patient's level of risk.** Factors that constitute increased risk for adverse outcomes include: having no prior medical records, declining to provide consent to speak with prior providers, history of non-concordant urine drug testing or PDMP histories, history of or active substance use disorder, comorbid psychiatric and medical conditions, co-prescription of opioids and benzodiazepines and prescribed opioid dose of MED≥90. A composite risk determination is made by integrating the above factors with the biopsychosocial assessment. Note that a medication regimen below MED of 90mg/day may still represent a high risk for adverse outcomes when other factors are present.

- **For a lower risk patient/medication regimen:** Consider initially continuing inherited regimen while building rapport, setting treatment goals and optimizing non-pharmacologic and non-opioid pharmacotherapy.
- **For a moderately high-risk patient/medication regimen:** Set clear boundaries, consider initiating medication changes to improve safety while applying principles from these guidelines. The long-term treatment plan may include an exit strategy from the use of long-term opioid therapy for chronic pain (See *Appendix E: How to approach an exit strategy from long-term opioid therapy*). It may not be appropriate to initiate opioid prescribing for patients who do not agree with a planned exit from long-term opioid therapy.
- **For a high-risk patient/medication regimen:** Avoid continuing the current treatment regimen, initiate safety planning (ensure not a danger to self or others) and provide other treatment options (refer to mental health, substance use disorder treatment, interdisciplinary pain teams, withdrawal support if indicated) and specifically provide non-opioid approaches to pain care.

Often patients at high risk have underlying untreated psychiatric and/or substance use disorders. It is critically important to offer appropriate treatment options for these patients: mental health treatment for psychiatric conditions and opioid agonist therapy when opioid use disorder is suspected or identified (see *Guideline #15*).

AFTER THE VISIT

- Do an initial follow-up and continue monitoring at a greater frequency (with shorter prescribing intervals), often every 1-2 weeks for the first several visits followed by every 2-4 weeks for the first 3-6 months.

APPENDIX C

HOW TO EVALUATE PATIENTS FOR OPIOID USE DISORDER

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APPENDIX C: HOW TO EVALUATE PATIENTS FOR OPIOID USE DISORDER[88]

The lifetime prevalence for opioid use disorder among patients receiving long-term opioid therapy has been estimated to be between 25-41%.[42]

Guideline #15 states to assess patients for opioid use disorder on a regular basis, and to offer or arrange for opioid agonist therapy to those diagnosed. There are screening tools available that can predict the likelihood of aberrant behaviors (e.g. Opioid Risk Tool, SOAPP-R), but they are not designed to screen for opioid use disorder and their sensitivity is low. **Providers should seek to identify clinical evidence of opioid use disorder, rather than relying on screening tests with low sensitivity.** When assessing for opioid use disorder and discussing opioid agonist therapy, clinicians should also aim to destigmatize the condition and the treatment. Reviewing the brain model of addiction[89] and comparing to other conditions (e.g. diabetes) that also require ongoing self-management and medication use can be helpful.

Definition and Diagnostic Criteria

Opioid use disorder (OUD) is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested **by at least two of the symptoms** below, occurring within a 12-month period. This can also be remembered through the "3Cs": Loss of **Control**, **Craving**, and Use despite Negative **Consequences**.

DSM-5 Diagnostic Criteria for Opioid Use Disorder[90]

LOSS OF CONTROL	Using larger amounts of opioids or over a longer period than initially intended	EXAMPLE: taking more than prescribed (e.g. repeated requests for early refills)
	Persistent desire or inability to cut down on or control opioid use	EXAMPLE: has tried to reduce dose or quit opioid because of family's concerns about use but has been unable to
	Spending a lot of time to obtain, use or recover from opioids	EXAMPLE: driving to different doctors' offices to get renewals for various opioid prescriptions
CRAVING	Craving or strong desire or urge to use opioids	EXAMPLE: describing constantly thinking about/needing opioid
USE DESPITE NEGATIVE CONSEQUENCES	Failure to fulfill obligations at work, school or home due to use	EXAMPLE: not finishing tasks due to effect of taking opioids; getting fired from jobs
	Continued opioid use despite persistent or recurrent social or interpersonal problems related to opioids	EXAMPLE: spouse of family member worried or critical about patient's opioid use
	Activities are given up or reduced because of use	EXAMPLE: no longer participating in weekly softball league despite no additional injury or reason for additional pain
	Recurrent use in situations that are physically hazardous	EXAMPLE: repeatedly driving under the influence
	Continued use despite physical or psychological problems related to opioids	EXAMPLE: unwilling to discontinue or reduce opioid use despite non-fatal accidental overdose
	Tolerance*	EXAMPLE: needing to take more to achieve the same effect
	Withdrawal*	EXAMPLE: feeling sick if opioid not taken on time or exhibiting withdrawal effects

*Tolerance and withdrawal are not counted as DSM V criteria for opioid use disorder when the patient is taking opioid medications as prescribed.

The severity of opioid use disorder is classified by the number of presenting symptoms.

DSM-5 Diagnostic Criteria for Severity of Opioid Use Disorder[90]	
Mild Severity of Opioid Use Disorder	Presence of 2-3 symptoms above
Moderate Severity of Opioid Use Disorder	Presence of 4-5 symptoms above
Severe Severity of Opioid Use Disorder	Presence of 6 or more symptoms above

If there is uncertainty whether a patient meets criteria for opioid use disorder, refer the patient to an addiction specialist or psychiatrist for diagnosis.

Next Steps

People with opioid use disorder are at risk for using illicit opioids (e.g. heroin or counterfeit pills, both of which can contain potent synthetic fentanyl) which can lead to death with small exposures.

- Avoid abrupt discontinuation or rapid tapering of opioid therapy unless there are certain high-risk circumstances (e.g. evidence for diversion, threatening behavior, serious disruptive behavior, suicidal ideation or behaviors).
- Offer patients with opioid use disorder opioid agonist therapy (e.g. methadone and buprenorphine) along with integrated pain and mental health therapy. This treatment can prevent overdose and death. Tapering alone is not sufficient treatment for this group.
- Recognize that opioid use disorder typically requires chronic management, although full remission can be achieved.

A Note on Diversion

Drug diversion is a crime and constitutes an absolute contraindication to prescribing additional medications. Drug diversion can be suspected if the patient history and clinical picture do not align, such as the absence of prescribed medications in a confirmatory urine drug test and no signs of clinical withdrawal despite a patient reported history of taking prescribed medications.

- Providers who suspect diversion should base treatment plans on objective evidence. Evidence can include a negative confirmatory urine drug test (e.g. gas chromatography/mass spectrometry or liquid chromatography/ mass spectrometry) for the substance being prescribed in the absence of withdrawal symptoms in someone who is receiving opioids. There is a limitation in this, however, as most routine urine drug screens do not detect synthetic opioids (e.g. methadone, fentanyl, tramadol) and may not detect semi-synthetic opioids (e.g. oxycodone, hydrocodone, hydromorphone).
- If there is evidence that the patient is diverting opioids, discontinue opioids and assess for underlying opioid use disorder and/or psychiatric comorbidities. Consultation with a pain specialist, psychiatrist, or substance use disorder specialist may be warranted. Consider additional consultation with risk management and/or legal counsel. For patients with opioid use disorder, opioid agonist therapy should be offered or arranged (see *Guideline #13*).

APPENDIX D

HOW TO CONNECT PATIENTS WITH MEDICATION-ASSISTED TREATMENT

ARIZONA DEPARTMENT
OF HEALTH SERVICES

APPENDIX D: HOW TO CONNECT PATIENTS WITH MEDICATION-ASSISTED TREATMENT

Medication-assisted treatment (MAT) is the use of long-acting opioid agonists to treat opioid use disorder, commonly in combination with counseling and behavioral therapies. Methadone and buprenorphine (Suboxone® and Subutex®) are the two medications approved for opioid agonist therapy. The opioid antagonist, naltrexone (Vivitrol®) is also used in the treatment of opioid use disorder but may have lower retention rates than MAT.

MAT is effective and the best form of treatment for opioid use disorder. MAT decreases opioid use, opioid-related overdose deaths, criminal activity and infectious disease transmission.[80] [81] [82] Patients treated with medication were more likely to remain in therapy compared to patients receiving treatment that did not include medication.[80]

This Appendix includes specific considerations for clinicians seeking to identify, initiate and monitor patients on MAT, an evidence-based treatment.

- **Identify patients with opioid use disorder, and destigmatize the diagnosis.** Patients with chronic pain and opioid use disorder are candidates for medication-assisted treatment (MAT).
  - Use patient-centered change talk instead of directive, prescriptive talk, See SAMHSA Motivational Interviewing, *integration.samhsa.gov/clinical-practice/motivational-interviewing*
  - See *Appendix C: How to evaluate patients for opioid use disorder.*
- **Counsel patients about the utility of MAT.**
  - Explain that the use of MAT is not substituting one addiction for another; MAT decreases opioid cravings and resolves opioid withdrawal.
  - Explain that MAT is effective, and that it decreases opioid use and opioid-related deaths.
  - Explain that methadone (and sometimes buprenorphine) is dispensed daily at opioid treatment programs, buprenorphine (Suboxone® and Subutex®) is an office-based treatment, and that both can assist patients with living full and engaged lives.
- **Facilitate smooth, bidirectional transitions between the pain treatment setting and the center providing medication-assisted treatment.**
  - Identify and contact local treatment programs to prepare for future patient use and referrals.
  - Contact the local treatment program to facilitate each patient's transition, found at *findtreatment.samhsa.gov/*
  - Provide a warm handoff for each patient to the program, rather than sending the patient out with a referral only.
  - Become a buprenorphine provider, waivers found at *samhsa.gov/medication-assisted-treatment*
- **Be aware of medication interactions when managing patients on MAT.**
  - If opioids are needed to treat acute pain, they should be used in coordination with a pain medicine specialist and MAT prescriber. Patients on MAT with acute pain requiring opioids are not at increased risk of relapse as long as they continue taking their MAT medication.[91] Patients with opioid use disorder not on MAT are at high risk for relapse when taking opioids for pain,[92] [93] [94] [95] and should be followed closely and provided anticipatory guidance, naloxone and overdose education.
  - Use caution when prescribing sedative/hypnotics like benzodiazepines with MAT, but do not withhold MAT in patients who are currently taking benzodiazepines when taken appropriately. The combined use of these drugs increases the risk of serious side effects, but the harm from untreated opioid addiction can outweigh these risks.[96]
  - Be aware of medication interactions with MAT.
    - Methadone: Prolonged QT with fluoroquinolones, macrolides, antiemetics and antipsychotics.
    - Buprenorphine: may increase effect of atazanavir (ART) and phenytoin; rifampin may produce opioid withdrawal.

APPENDIX E

HOW TO APPROACH AN EXIT STRATEGY FROM LONG-TERM OPIOID THERAPY

ARIZONA DEPARTMENT
OF HEALTH SERVICES

APPENDIX E: HOW TO APPROACH AN EXIT STRATEGY FROM LONG-TERM OPIOID THERAPY

Opioid tapering is the seemingly logical approach to stopping long-term opioid therapy and patients can experience improved pain, function and quality of life when opioids are tapered and discontinued, particularly when tapering occurs in the context of a whole-person care plan. There are some patients, however, such as those with opioid use disorder, for whom tapering may contribute to the overall risk calculation (e.g. possibly increasing the risk of illicit opioid acquisition or worsening of underlying psychiatric illnesses).

Clinicians should consider a broader concept of an opioid exit strategy. As recommended in *Guideline #17,* two additional exit strategies beyond tapering (Strategy (a)) include rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose (Strategy (b)), and medication-assisted treatment for patients with opioid use disorder (Strategy (c)). There is clear evidence for the effectiveness of treating an opioid use disorder with medication-assisted treatment, but otherwise little evidence to guide which opioid exit strategy is best for an individual. The following can be considered in choosing an initial strategy, but a switch to another strategy can be made at any time, depending on the clinical situation:

- For patients with prescriptions of lower MEDs, lower pain-related dysfunction, and lower psychiatric and substance use disorder comorbidities, consider opioid tapering (Strategy (a)). See the Opioid Tapering subsection within this *Appendix.*
- For patients with prescriptions of higher MEDs, higher pain-related dysfunction and higher psychiatric and substance use disorder comorbidities, consider Strategy (b), rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose.
- For patients with opioid use disorder, offer or arrange for medication assisted treatment (Strategy (c)). See *Guideline #15* and *Appendices C* and *D* for diagnosis and management of opioid use disorder.

Complex persistent opioid dependence is a condition recently described in the literature as a clinical and physiologic state that exists on the continuum between simple opioid dependence (which presents with short-lived and self-limited withdrawal symptoms after opioids are discontinued) and opioid use disorder (defined by DSM-5 criteria). In these patients, opioid tapering or cessation may lead to worsening pain, function, affective symptoms and sleep disturbances. As of the writing of this guideline, there is no clear evidence to guide the best exit strategy for these patients, but options include Strategy (a) (opioid tapering), while optimizing treatment of psychiatric comorbidities, non-pharmacologic and non-opioid pharmacotherapy for pain or (Strategy (b)), buprenorphine followed by its gradual dose reduction.

Abrupt opioid discontinuation is not recommended unless required for immediate safety concerns.

Opioid Tapering

The following risks should be taken into consideration when determining the overall risks with long-term opioid therapy for pain, recognizing that having multiple risk factors indicates a larger, cumulative risk:

- No pain reduction, no improvement on opioid regimen
- Severe, unmanageable adverse effects (drowsiness, constipation)
- High risk dosage (e.g. ≥90 MED)
- Non adherence to treatment plans
- Concerns related to an increased risk of substance use disorder
- Overdose event involving opioids
- Medical comorbidities that can increase risk (e.g. lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age)
- Concomitant use of medications that increase risk (benzodiazepines, sedative-hypnotics)
- Mental health comorbidities that can worsen with opioid therapy (e.g. PTSD, depression, anxiety)

Before Starting Taper

- Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper, such as mental health disorders, opioid use disorder and other substance use disorders, medical comorbidities and sleep disorders.
- Discuss risks and benefits of continued use of opioids with patient, including that tolerance to the prior opioid dose can be lost within a week and people are at risk of an overdose if they resume their prior dose.[97]
- Offer Naloxone as a safety measure to all patients at risk for overdose (see *Guideline #16*).

- Identify a multimodal care team, made up of behavioral health specialists and addiction specialists to assist during the taper.
- Acknowledge fears about tapering, and help patients develop goals for life (besides being "pain-free") and offer other nonpharmacological or non-opioid medications.
- Determine speed of taper: Slow tapers are often the most tolerable and can be completed over several months to years, but more rapid tapers may be required in instances like illegal or dangerous behaviors or situations where the risks of continuing the opioid outweigh the risks of a rapid taper.

Example Tapers for Opioids[98 99 100 101 102]			
Slowest Taper (over years)	**Slower Taper (over months to years) *MOST COMMON***	**Faster Taper (over weeks)**	**Rapid Taper (over days)**
Reduce MEDs by 2-10% every 4-8 weeks with pauses in taper as needed.	Reduce MEDs by 5-20% every 4 weeks with pauses in taper as needed.	Reduce MEDs by 10-20% every week.	Reduce MEDs by 20-50% of first dose if needed, then reduce by 10-20% every day.

Follow-up and Support During Taper

- Provide opioid overdose education and prescribe naloxone to patients, given the reduced tolerance to opioids and availability of opioids in the community (see *Guideline #16*).
- Follow-up on patient function, pain intensity, sleep, physical activity, personal goals and stress level – the frequency and location of follow-up determined by the tapering approach.

Follow-up during opioid tapers[98 99 100 101 102]			
Slowest Taper (over years)	**Slower Taper (over months to years) *MOST COMMON***	**Faster Taper (over weeks)**	**Rapid Taper (over days)**
Follow up every 1-4 weeks after starting taper then monthly before each reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up every 1-4 weeks after starting taper then monthly before each reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up weekly before each dose reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up daily before each dose reduction or offer inpatient admission.

- For patients who struggle with opioid tapering, consider slowing or pausing the taper and evaluate for psychiatry comorbidities and substance use disorders. A switch to another exit strategy may be appropriate. Consider switching to Strategy (b), rotation to buprenorphine with subsequent gradual tapering over several months if complex persistent opioid dependence is suspected. Further, consider switching to Strategy (c), (medication assisted treatment) if opioid use disorder is recognized during the tapering process of the opioid or buprenorphine dose.
- Generally, withdrawal symptoms can be minimized or avoided with gradual tapers. Reassure patients that withdrawal symptoms can be managed with medication and non-medication treatments (e.g. meditation, relaxation, deep breathing).[42 98 99 100 101 102 103 104 105 106 107 108 109] Withdrawal symptoms should not be treated with an opioid or benzodiazepine. Treatment should be provided or arranged when these conditions are present.

Indication	**Treatment Options**
Autonomic symptoms (sweating, tachycardia, myoclonus)	First line: Clonidine; Alternatives: Baclofen, Gabapentin, Tizanidine
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine, Diphenhydramine
Myalgias	NSAIDs, Acetaminophen, Topical medications like menthol/methyl salicylate cream, lidocaine cream/ointment
Sleep disturbance	Trazodone
Nausea	Prochloperazine, Promethazine, Ondansetron
Abdominal cramping	Dicyclomine
Diarrhea	Loperamide, Bismuth subsalicylate

APPENDIX F

HOW TO MANAGE PAIN AND OPIOIDS IN SPECIAL POPULATIONS

ARIZONA DEPARTMENT
OF HEALTH SERVICES

APPENDIX F: HOW TO MANAGE PAIN AND OPIOIDS IN SPECIAL POPULATIONS

While the concepts detailed in the *Arizona Opioid Prescribing Guidelines* are applicable to patients receiving specialty care, this appendix details additional, specific considerations for post-surgical patients, pediatric patients, dental and elderly patients.

SURGICAL PATIENTS [110] [111] [112]

The Arizona *Guidelines* are not intended to apply to inpatient trauma, burn or major, complex post-operative patients. They are applicable, however, in the outpatient post-operative setting, and the transition from the inpatient to outpatient setting for most post-operative patients. Of note, it is not expected to see these patients 3-5 days post-operatively if there are no clinical issues or concerns; these suggestions should be used in conjunction with regular post-operative follow-up schedules.

A 2017 systematic review found that post-operative prescription opioids often go unused, unlocked and undisposed. More than two-thirds of patients reported unused prescription opioids following surgery, consistent across several studies of general, orthopedic, thoracic and obstetric inpatient and outpatient surgeries.[16] Therefore, best practices for post-operative pain management include the following:

- Conduct a pre-operative evaluation including assessment of medical and psychiatric comorbidities and history of chronic pain and substance use, in order to guide the perioperative pain management plan.
- Provide preoperative patient education about realistic expectations about pain and healing after surgery.[112]
    - Set expectations – "Some pain is normal. You should be able to walk and do light activity, but may be sore for a few days. This will gradually get better."
    - Set norms – "Half of patients who have this procedure take fewer than 10-15 pills."
    - Endorse non-opioid use – "Take acetaminophen and ibuprofen around the clock, and use the stronger pain pills only as needed for breakthrough pain."
        - Avoid NSAIDs in patients with peptic ulcer disease and associated risk factors (smoking, drinking), bleeding disorders, renal disease and specific operations at surgeon discretion.
        - Advise that NSAID use for postoperative pain is for a finite amount of time.
    - Stress appropriate opioid use – "These pills are for pain from your surgery, and should not be used to treat pain from other conditions."
    - Educate about adverse effects – "We are careful about opioids because they have been shown to be addictive, cause you harm and even cause overdose if used incorrectly or abused."
    - Advise safe disposal – "Disposing of these pills prevents others, including children, from accidentally overdosing. You can take pills to an approved collector (including police stations), or mix pills with kitty litter in a bag and throw them in the trash."
- Offer multimodal analgesia for the treatment of postoperative pain.
    - *Nonpharmacologic options:* TENS, cognitive behavioral therapy, possible benefit from acupuncture, massage, cold therapy, localized health and continuous passive motion.
    - *NSAIDs and/or acetaminophen:* a single dose of oral celecoxib 200-400mg given 30-60 minutes prior to surgery is associated with lower opioid requirements after surgery[113] NSAIDs are contraindicated for perioperative pain in patients undergoing CABG and for 14 days after CABG due to increased risk of cardiovascular events.
    - *Gabapentin or pregabalin:* useful for thoracotomy, laparotomy, joint replacement, CABG, spinal fusion as it is associated with reduced opioid requirements before surgery.[113]
    - *Local/regional blocks:* regional blocks (like transversus abdominis plane (TAP) block for major abdominal operations) with long-acting medications such as liposomal bupivacaine (when appropriate) to reduce opioid use. Local field blocks could also be used in such cases like open inguinal hernia repairs in order to decrease opioid use.

- Develop procedure-specific opioid prescription strategies. Online tools such as michigan-open.org can guide post-operative prescribing habits, based on the most up-to-date research and recommendations. Examples below come from the Michigan Opioid Prescribing Engagement Network, led by surgeons and anesthesiologists, and are applicable to opioid-naive patients.

PROCEDURE-SPECIFIC OPIOID PRESCRIBING STRATEGIES

Procedure	Hydrocodone (Norco) - 5 mg tablets Codeine (Tylenol #3) - 30 mg tablets Tramadol - 50 mg tablets	Oxycodone 5 mg tablets
Laparoscopic Cholecystectomy	15	10
Laparoscopic Appendectomy	15	10
Inguinal/Femoral Hernia Repair (Open/Laparoscopic/Robotic)	15	10
Open Incisional Hernia Repair	40	25
Laparoscopic Colectomy	35	25
Open Colectomy	40	25
Hysterectomy Vaginal Laparoscopic & Robotic Abdominal	 20 30 40	 15 20 25
Wide Local Excision +/- Sentinel Lymph Node Biopsy	30	20
Simple Mastectomy +/- Sentinel Lymph Node Biopsy	30	20
Lumpectomy +/- Sentinel Lymph Node Biopsy	15	10
Breast Biopsy or Sentinel Lymph Node Biopsy	15	10

Recommendations were based on patient-reported data from the Michigan Surgical Quality Collaborative and other published studies. Recommended amounts meet or exceed self-reported use of 75% of patients. Previous studies have shown that when patients are prescribed fewer pills, they consume fewer pills with no change in pain or satisfaction scores. Many patients use 0-5 pills. Recommendations are for patients with no preoperative opioid use. For patients taking opioids preoperatively, prescribers are encouraged to use their best judgment.

- Do not provide enough pain medications to "tide someone over;" provide what is medically necessary.
- For opioid-tolerant patients undergoing elective surgery, consult with pain medicine or addiction specialists.
    - Studies of abdominal surgery, joint arthroplasty and spinal surgery have shown preoperative opioid use is a significant predictor of adverse patient-reported outcomes.[113]
    - In collaboration with the prescriber of long-term opioid therapy, consider opioid tapering prior to elective surgeries and delaying surgery if necessary to provide additional time for pre-surgical optimization.
- Consider developing and implementing enhanced recovery pathways for post-operative patients.
    - See American College of Surgeons' *AHRQ Safety Program for Improving Surgical Care and Recovery:* facs.org/quality-programs/iscr
    - See Society of American Gastrointestinal and Endoscopic Surgeons' (SAGES) *SMART™ Enhanced Recovery Program:* sages.org/smart-enhanced-recovery-program

PEDIATRIC PATIENTS

Like adults, pediatric patients experience acute and chronic pain. There are two primary areas of concern with pediatrics: the accidental poisonings of young infants and children, and the exposure/experimentation that may lead to opioid use disorders in adolescents. Cohort and survey studies have found that opioid use disorder is a leading cause of morbidity and mortality among U.S. youth.[114]

For acute pain management:

- Use opioids only in children with moderate or severe pain, or pain that is refractory to non-opioid analgesics.
    - Agents not recommended: In 2017, FDA issued warnings and contraindications for the use of codeine and tramadol for pain management in all children < 12 years old.[115]
- Counsel parents about the need for safe storage of their own opioids and controlled substances. Most adolescents who misuse opioids often access them through a friend or family member.[116]

For chronic pain management:

Chronic pain disorders are common in children and teenagers. Up to 8% of children experience debilitating chronic pain and around 3% require intensive rehabilitation.[117] [118] [119] Further, around 17% of adult chronic pain patients report a history of chronic pain in childhood or adolescence.[120] Mental health disorders such as anxiety and depression are early risk factors for developing chronic pain, impairing the patient's ability to cope with the pain and escalating the perceived pain level.

- Recognize that the pediatric population may have unique vulnerabilities and inappropriate and/or prolonged exposure to opioids may lead some to develop addiction, drug-seeking behavior and the misuse of prescription opioids.
- Strongly recommend not using opioids to treat chronic pain in pediatric patients.
    - Use of prescribed opioids before the 12th grade is independently associated with future opioid misuse among patients with little drug experience and the vast majority of substance use is initiated in adolescence.
    - Use of opioids to treat chronic pain may lead to opioid-induced hyperalgesia and catalyze the sensitization process, leading to progression of the child's pain.
- Use a multimodal approach to treat chronic pain in pediatric patients.
    - *Non-opioid medications:* includes gabapentin, alpha-2-agonists, low dose amitriptyline and lidocaine creams or patches.

- *Supplements:* includes magnesium, omega 3 fish oils, vitamin D and melatonin.
- *Integrative medicine techniques:* includes diaphragmatic breathing, aromatherapy, biofeedback, mindfulness and yoga.
- *Physical therapy:* to be considered for all patients with chronic pain.

- Refer pediatric patients with chronic pain to psychology to decrease catastrophizing, provide coping mechanisms and teach relaxation and distraction techniques.
- Recommend and refer to family therapy as needed.
- Incorporate nutrition and daily exercise into the treatment plan.

Screening and treatment for substance use disorder:

- Screen pediatric patients for substance use as part of an age-appropriate comprehensive history, using 4Ps or CRAAFT.
  - The 4 P's: **Parents** (Did any of your parents have a problem with alcohol or other drug use?), **Partner** (Does your partner have a problem with alcohol or drug use?), **Past** (In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?) and **Present** (In the past month, have you drunk any alcohol or used other drugs?). Any "yes" should trigger further questions.
  - CRAFFT: brightfutures.aap.org/Bright%20Futures%20Documents/Screening.pdf.
- Consider medication-assisted treatment as an option for pediatric patients with opioid-use disorder.
  - Medication-assisted treatment has been recommended by the American Academy of Pediatrics for adolescent and young adult patients with severe opioid use disorders.[114]

DENTAL PATIENTS[121]

Dentists cannot assume that their prescribing of opioids does not affect the opioid use problem. There is a risk of opioid-related adverse events even with acute, short-term therapy. Dentists are among the top prescribers of opioids to teenagers.[122]

- Develop procedure-specific opioid pain management strategies, based on peer-reviewed recommendations for analgesia.
- Utilize multimodal pain strategies for management of acute postoperative pain, as a means for sparing the need for opioid analgesics.
- Consider the use of long-acting local anesthetics to manage post-surgical pain.
- Coordinate with other treating doctors, including pain specialists and primary care, when prescribing opioids for management of chronic orofacial pain.
- Do not provide enough pain medications to "tide someone over"; provide what is medically necessary.

OLDER ADULTS[123 124 125]

Chronic or persistent pain is a common problem in older adults. There are age-associated differences in the effectiveness and toxicity of opioid therapy, given age-related alterations in drug absorption, distribution, metabolism and excretion.

- Nonpharmacologic therapies and topical therapies are first line treatment for pain management in older adults.
  - Topical NSAIDs, capsaicin and lidocaine have the advantage of low risk of adverse events and ease of use.
- Consider acetaminophen as initial and ongoing pharmacotherapy in the treatment of persistent pain, particularly musculoskeletal pain.
  - Absolute and relative contraindications to acetaminophen use in this population include liver failure, hepatic insufficiency (up to 2g acetaminophen may still be indicated), chronic alcohol use and/or dependence.
- Consider NSAIDS like ibuprofen and naproxen for mild or moderate chronic pain, if the person has no contraindications.
  - Nonselective NSAIDS and COX 2 selective inhibits should be used with extreme caution.
  - Patients taking aspirin for cardioprophylaxis should not use ibuprofen.
  - NSAIDs should not be used in the case of heart failure of eGFR > 30 mL/min.
  - PPI should be provided for gastroprotection.
  - Indomethacin and ketorolac should be avoided for mild or moderate chronic pain.
- Avoid opioids if history of falls or fractures, unless it is being used for pain management due to recent fractures or joint replacement.
  - Opioids have been added to the list of CNS medications that should be avoided in individuals with a history of falls or fractures.
- If opioids are indicated, anticipate, assess for, and identify potential opioid-associated adverse effects.
  - The Beers criteria offers medications and combinations of medication that should be avoided or used with caution.[124]
  - Polypharmacy is a common danger; older adults use an average of 2-5 prescription medications on a regular basis.
- If opioids are indicated, reduce the use or dosage of other CNS medications being used.
- Use caution with benzodiazepines since older adults have increased sensitivity to them.
  - In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures and motor vehicle crashes in older adults.

APPENDIX G

HOW TO CONNECT WITH LOCAL AND NATIONAL RESOURCES

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APPENDIX G: HOW TO CONNECT WITH LOCAL AND NATIONAL RESOURCES

Arizona resources can provide prescribers with local data and practical ways to maintain subject matter expertise, find treatment providers and keep patients and their communities safe with naloxone and safe drug disposal.

- **See local data** about the epidemiology of opioid use and sequelae from Arizona's surveillance.
  azhealth.gov/opioid

- **Reference and forward the *Arizona Opioid Prescribing Guidelines (2017)*** and related prescribing resources.
  azhealth.gov/opioidprescribing

- **Consult 24/7** with Arizona experts regarding complex patients with pain and opioid use disorder, recommendations on exit strategies and referrals to medication-assisted treatment.
  Real-time consultation line, 888-688-4222

- **Use standing orders for Naloxone,** signed by Dr. Cara Christ at the Arizona Department of Health Services.
  azdhs.gov/naloxone-standing-orders

- **Distribute naloxone information** to parents and caregivers.
  azdhs.gov/naloxone-brochure-public

- **Find treatment** for substance use in Arizona.
  substanceabuse.az.gov/substance-abuse/treatment

- **Find safe disposal locations** for Arizonans to dispose of their unused controlled substances.
  dumpthedrugsaz.org

- **Gain CME and expertise** in pain management in Arizona.
  vlh.com/AZPrescribing

- **Provide patients with self-management strategies** for chronic pain.
  azhealth.gov/chronicpainmanagement

- **Identify substance-exposed newborns,** using a 2016 publication from an Arizona statewide task force as a reference.
  azdhs.gov/substance-abused-newborns-fact-sheet

National resources for providers include federal agency guidelines, medical association committee opinions, federal regulations and warnings and waiver-trainings.

- **Read** the *Veterans Administration / Department of Defense Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (2017), particularly the Recommendation Summary on Page 6.
  healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPGProviderSummary022817.pdf

- **Read** the *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*, particularly the summary in Box 1.
  cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

- **Read** the 2017 *ACOG/ASAM Committee Opinion on Opioid Use and Opioid Use Disorder in Pregnancy (2017)*.
  acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy

- **Educate patients on the DEA restrictions** on the sharing of controlled substances.
  azleg.gov/ars/13/03406.htm

- **Incorporate the FDA Black-Box Warning** about Opioids and Benzodiazepines into patient informed consent and counseling.
  fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm518110.htm

- **Apply for a Buprenorphine Waiver** to be able to treat opioid use disorder.
  samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management

- **Find treatment locations in your area** for patients with substance use disorder and/or mental health problems.
  findtreatment.samhsa.gov/

APPENDIX H

HOW TO REFERENCE THE UPDATED ARIZONA GUIDELINES FOR EMERGENCY DEPARTMENT CONTROLLED SUBSTANCES PRESCRIBING

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APPENDIX H: HOW TO REFERENCE THE UPDATED ARIZONA GUIDELINES FOR EMERGENCY DEPARTMENT CONTROLLED SUBSTANCES PRESCRIBING

The Arizona Guidelines for Emergency Department Controlled Substances Prescribing were developed to help emergency departments reduce the inappropriate use of controlled substances while preserving the vital role of the emergency department to treat patients with emergent medical conditions.

These guidelines have been updated from its original version in 2015, to this version in 2018. These updated guidelines are in a similar tone and content to the *Arizona Opioid Prescribing Guidelines (2018)*.
azdhs.gov/az-emergency-prescribing-guidelines

APPENDIX I

HOW TO CORRECT CLINICAL MISPERCEPTIONS ABOUT OPIOIDS

ARIZONA DEPARTMENT
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APPENDIX I: HOW TO CORRECT CLINICAL MISPERCEPTIONS ABOUT OPIOIDS

The evidence behind and approach to opioid use, pain management and opioid use disorder have evolved over time. The following clarifications are based on the most recent evidence, and summarize the key concepts described throughout these *Arizona Opioid Prescribing Guidelines.*

Q1: IS THERE EVIDENCE THAT OPIOIDS ARE EFFECTIVE FOR CHRONIC PAIN?

There is no evidence that establishes the long-term benefits of pain relief, function and quality of life when long-term opioids are used for chronic pain. On the other hand, there are several studies showing the risks associated with long-term opioid use, which increase with increasing dose and duration of opioid use.

See Guideline #5: "Do not initiate long-term opioid therapy for most patients with chronic pain."

Q2: IS TRAMADOL A SAFE MEDICATION FOR MANAGING PAIN?

Tramadol is an opioid. Use of tramadol is a risk factor for continued opioid use. There are increased adverse effects when tramadol is combined with benzodiazepines, opioid pain medications and/or alcohol. Due to its concurrent inhibition of serotonin and norepinephrine uptake, coadministration of tramadol with other agents that increase serotonergic activity can precipitate serotonin syndrome and caution should be used.

See Guideline #2: "There is no absolute safe dose of opioids."

Q3: IF A PATIENT'S URINE DRUG SCREEN IS NEGATIVE, IS MISUSE TAKING PLACE? IF A PATIENT'S URINE DRUG SCREEN IS POSITIVE, IS MISUSE TAKING PLACE?

Urine screening tests comprise of initial qualitative tests (e.g. immunoassays) and confirmatory tests (e.g. gas chromatography/mass spectrometry or high performance liquid chromatography). There is a differential diagnosis for both positive and negative urine drug screens. For example, a negative urine drug screen for a patient taking oxycodone may occur in all of the following situations: the patient is not taking oxycodone because he is taking it less frequently than prescribed, the patient is not taking oxycodone because he is selling it, or the patient is taking oxycodone but the urine drug screen does not reliably detect semi-synthetic opioids. Likewise, for a patient who is prescribed long-acting morphine, a urine drug screen that is positive for opiates and amphetamines may occur if the patient is taking morphine as prescribed and also taking bupropion, which can produce a false positive amphetamine result or if the patient is selling morphine and using heroin and methamphetamine. Confirmatory urine drug testing and patient history can assist in making the appropriate diagnosis in the above examples.

See Guideline #14: "Clinicians should interpret the results based primarily on clinical findings and prescription history, not just the screening test results."

Q4: IF PATIENTS DON'T GET THEIR OPIOID PRESCRIPTIONS REFILLED, WILL THEY DIE FROM OPIOID WITHDRAWAL?

Opioid withdrawal can be very uncomfortable and distressing, but is rarely a medical emergency. Benzodiazepine withdrawal, however, can be life-threatening.

See Appendix C: "Reassure patients that [opioid] withdrawal symptoms can be managed with medication and non-medication treatments…. [and] not… with an opioid or benzodiazepine."

Q5: DO ADVERSE EFFECTS FROM OPIOIDS ONLY HAPPEN WITH HIGH DOSES OVER LONG PERIODS OF TIME?

There are risks of opioid-related adverse events even during acute, short-term therapy. With daily opioid use, physical dependence and tolerance can develop in days or weeks. Accidental death results from short-term therapy, particularly if opioids are combined with benzodiazepines, alcohol, or the patient has comorbid medical and psychiatric conditions.

See Guideline #1: "Use non-opioid medication and therapies as first-line treatment for mild and moderate acute pain," Guideline #2: "Initiate [opioid] therapy [for acute pain]… for no longer than a 3-5 day duration" and Guideline #5: "Do not initiate long-term therapy for most patients with chronic pain."

Q6: ARE EXTENDED-RELEASE/LONG-ACTING OPIOIDS BETTER THAN SHORT-ACTING OPIOIDS FOR MANAGING CHRONIC PAIN?

Extended-release/long-acting opioids have not been proven to be safer or more effective than short-acting opioids for managing chronic pain, and have been associated with increased risk of all-cause mortality.

See Guideline #4: "Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain" and Guideline #5: "Do not initiate long-term opioid therapy for most patients with chronic pain." And for acute pain, Guideline #2: "Do not use long-acting opioids for the treatment of acute pain."

Q7: IS THE CSPMP A TOOL USED TO CATCH PATIENTS LYING ABOUT THEIR OPIOID PRESCRIPTIONS?

Use of the AZ CSPMP provides objective data to assist with identification of harmful medication interactions or evidence of multiple providers prescribing controlled substances. This objective data can help clinicians develop a whole person care plan and is not intended to be used as a lie-detector.

See Guideline #10: "Check the Arizona Controlled Substances Prescription Monitoring Program before initiating an opioid or benzodiazepine prescription."

Q8: DO OPIOID RISK SCREENING TOOLS (ORT, SOAPP-R) INDICATE WHETHER PATIENTS HAVE OPIOID USE DISORDER?

There are screening tools that are intended to predict the likelihood of aberrant behaviors, but they are not designed to screen for or diagnose opioid use disorder. Of note, these tests have low sensitivities.

See Appendix C: "Providers should seek to identify clinical evidence of opioid use disorder, rather than relying on screening tests with low sensitivity."

Q9: DO ALL PATIENTS NEED TO BE TAPERED OFF OPIOIDS?

Opioid tapering is one of several exit strategies to long-term opioid use, and may not be appropriate for all patients. While some patients can experience improved pain, function and quality of life after tapering, some with opioid use disorder or complex persistent opioid dependence can experiencing worsening symptoms. If tapering is chosen as the opioid exit strategy, it must not be approached casually, too rapidly or with a "one-size-fits-all" mentality.

See Guideline #17: "Individualize an exit strategy [options including tapering, buprenorphine then tapering, or treatment for opioid use disorder] for all patients on long-term opioid therapy."

Q10: IS THERE ANY EFFECTIVE TREATMENT FOR OPIOID USE DISORDER?

Medication-assisted treatment (MAT) is the use of medications to treat opioid use disorder, commonly in combination with counseling and behavioral therapies. MAT is effective and the best form of treatment for opioid use disorder. MAT decreases opioid use, opioid-related overdose deaths, criminal activity and infectious disease transmission. Patients treated with medication were more likely to remain in therapy compared to patients receiving treatment that did not include medication.

See Guideline #15: "Assess patients for opioid use disorder on a regular basis and offer or arrange for medication-assisted treatment (e.g. methadone and buprenorphine) to those diagnosed."

Q11: IS MEDICATION-ASSISTED TREATMENT (MAT) REPLACING ONE ADDICTION WITH ANOTHER?

Methadone and buprenorphine (medications used for MAT) are opioids, but the medication does not allow patients to get high. It actually helps reduce opioid cravings and withdrawal.

See Guideline #15: "Assess patients for opioid-use disorder on a regular basis and offer or arrange for opioid agonist therapy (i.e. methadone or buprenorphine) to those diagnosed."

Q12: CAN MEDICATION-ASSISTED TREATMENT (MAT) BE USED IN THE VULNERABLE POPULATIONS OF PREGNANT WOMEN, PEDIATRICS AND THE ELDERLY?

With certain cautions, MAT has been recommended for use in adolescents and young adults, pregnant women and the elderly.

See Guideline #15: "Assess patients for opioid-use disorder on a regular basis and offer or arrange for medication assisted treatment (e.g. methadone and buprenorphine) to those diagnosed."

Q13: DOES ABSTINENCE WORK AS WELL AS MEDICATION-ASSISTED TREATMENT (MAT)?

For patients with opioid use disorder, withdrawal management (otherwise known as detoxification) in isolation, is less effective compared to MAT and significantly increases the risk of relapse, treatment failure and subsequent overdose.

See Guideline #15: "Assess patients for opioid-use disorder on a regular basis and offer or arrange for medication assisted treatment (e.g. methadone and buprenorphine) to those diagnosed."

Q14: IS OPIOID USE AND OVERDOSE AN EPIDEMIC?

The term "epidemic" means an increase, often sudden, in the number of cases of a disease above what is normally expected in a population. The CDC and Federal Department of Health and Human Services have referred to an opioid epidemic in response to the increasing opioid-related deaths. Since 1999, the number of overdose deaths involving opioids in the United States have quadrupled. In Arizona, more than 2 people die every day from an opioid overdose, and data from Arizona's 2017 Enhanced Surveillance suggest this may be an underestimate.

See Purpose of the Guidelines: "Prescribing practices have contributed to the current opioid crisis and there needs to be a shift in prescribing culture."

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