

Educational Objectives

- Recognize the potential for opioid misuse and abuse in people prescribed opioid analgesics for chronic pain.
- Implement tools to assess for the risk of misuse and abuse in patients prescribed opioid analgesics.
- Integrate currently available practices to curb opioid misuse and abuse in your practice.

Definitions: Misuse and Abuse

- Misuse:** Intentional or unintentional use of medication for medical purpose other than as directed.
- Abuse:** Use of illegal drug or intentional self-administration of medication for nonmedical purpose.

American College of Preventive Medicine.
<http://www.acpm.org/7UseAbuseRxClinRef#Prevalence>. Passik SE, et al. Palliative Care and Supportive Oncology. 2002

Definitions associated with opioid use

Addiction	Primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. May be characterized by impaired control over drug use, compulsive use, continued use despite harm, and craving.
Pseudoaddiction	Syndrome resulting from undertreatment of pain that is misidentified by the clinician as inappropriate drug-seeking behavior. Behavior ceases when adequate pain relief is provided. Not a diagnosis; rather, a description of a clinical interaction.
Physical dependence	State of adaptation manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and administration of an antagonist.
Tolerance	State of adaptation in which exposure to a given drug dose induces biologic change resulting in diminution of one or more of the drug's effects over time. Alternatively, escalating doses of a drug are required over time to maintain a given level of effect.

The number of pain medication prescriptions correlates well with the prevalence of chronic pain

100.0
80.0
60.0
40.0
20.0
0.0

Americans affected (millions)

Chronic pain Diabetes CHD Stroke Cancer

*More than the other serious diseases listed combined

Inset figure: http://www.painmed.org/patientcenter/facts_on_pain.asp#prevalence.
*Vaccaro et al. British Journal of Anaesthesia. 2010;105:669-685.
Inset figure: <http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-oxycodone-prescription-drug-abuse>.

The U.S. opioid overdose epidemic – a top public health challenge

- Use of opioid analgesics has increased steadily from 2000 through 2012¹
- Trend driven by expanded use of opioid analgesics for chronic non-cancer pain
- During the same time frame, overdose deaths involving opioid analgesics have nearly quadrupled²
- 207 million prescriptions for the three most commonly prescribed opioid analgesics were dispensed in US pharmacies in 2013³

Prescription Opioid Drug Use in the United States 2000-2012¹

United States DDDs, million inhabitants

Years

*DDs, Defined daily dose

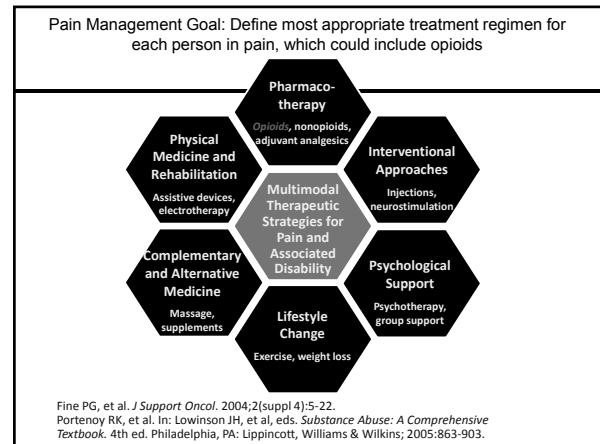
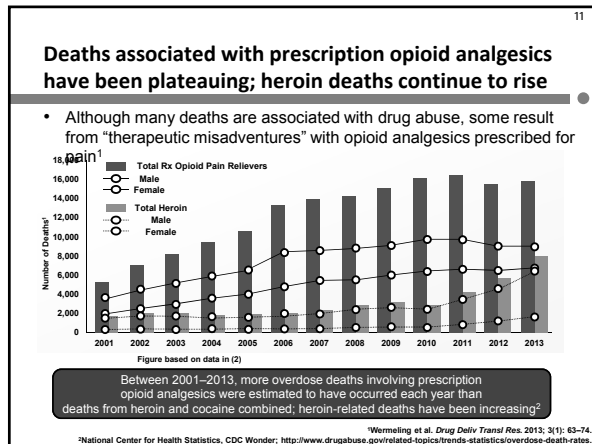
¹International Narcotics Control Board; Narcotic Drugs—Annual Technical Reports (2003-2013).
²Kolodny et al. Annu Rev Public Health. 2015;36:559-74
³IMS Health, National Prescription Audit, years 1997-2013

Opioid harm is not limited to non-medical users: the Opioid Continuum

- Misuse can include use with other CNS depressant drugs, dosing errors, or use for non-pain-related purposes (ie, abuse)

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graph TD
    OpioidUse[Opioid use] --> Treatment[Treatment for opioid-dependence]
    OpioidUse --> IllicitUse[Illicit use]
    OpioidUse --> Prescribed[Prescribed]
    Treatment --> Relapse[Relapse]
    Relapse --> Overdose[Overdose]
    IllicitUse --> Overdose
    Prescribed --> MedicalManagement[Medical management]
    MedicalManagement --> Misuse[Misuse]
    Misuse --> Overdose
    Overdose --> Death[Death]
  
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Rational use of opioid analgesics for chronic cancer and non-cancer pain

- Dichotomy of "pro-opioid" and "anti-opioid" is false, and does not serve healthcare professionals, patients, or society well
 - Ethical healthcare providers are "pro-health" and make treatment decisions within that context
- Clinicians must
 - Learn how to select patients for opioid therapy, when indicated
 - Manage patients on opioid therapy as safely and effectively as possible

Opioid Receptors

- Administered opioids bind to the same three receptor subtypes that normally bind endogenous opioid peptides¹
 - μ (MOP): Analgesia, sedation, respiratory depression, bradycardia, nausea, vomiting, reduced gastric motility
 - δ (DOP): Spinal/supraspinal analgesia, reduced gastric motility
 - κ (KOP): Spinal analgesia, diuresis, dysphoria
- Opioids can be classified according to their effect at opioid receptors¹
 - Agonists: act at a receptor to produce maximal receptor-mediated responses; eg, morphine and analgesia
 - Antagonists: bind to a receptor but do not cause a functional response; binding prevents an agonist from binding to that receptor, however, eg, naloxone
 - Partial agonists: can bind to a receptor but result in only partial functional response, independent of the amount of drug administered, eg, buprenorphine
- Most clinically administered opioid analgesics bind to μ (MOP)

¹Pathan H and Williams J. *British Journal of Pain*. 2012; 6(1):11-16.

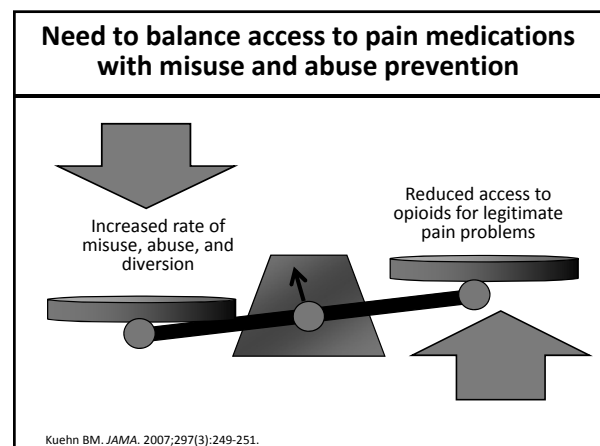
Opioids have benefits for many patients with chronic pain

- Not all patients become dependent or addicted
- Most patients do not experience overdose and death
- Many patients respond well if not at first to one opioid, then to an alternative opioid(s) and at doses within recommended ranges¹
- But not all types of chronic pain are optimally treated with opioid therapy
 - Headache
 - Fibromyalgia
 - Chronic abdominal pain
- However, there may be more than one pain type in a given patient

Drug	Approximate equianalgesic dose ²
Morphine (reference)	30 mg
Fentanyl transdermal	12.5 μ g/h
Hydrocodone	30
Hydromorphone	7.5
Oxycodone	20
Oxymorphone	10
Codeine	200

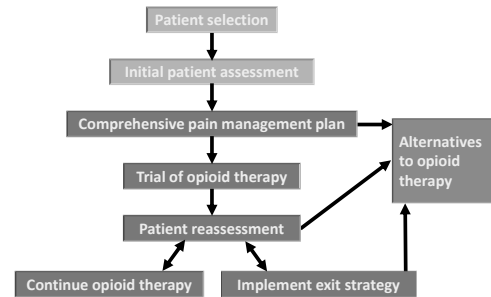
¹oral and transdermal
Table adapted from (1)

¹60–120 mg/day, MED, in Franklin G. *Neurology*. 2014; 83:1277–1284.



What can we clinicians do?

Proposed critical thinking model for chronic opioid therapy



Goals of clinical assessment

- Achieve diagnosis of pain
- Identify and treat underlying causes of pain
- Identify and treat comorbid conditions
- Evaluate psychosocial factors
- Evaluate functional status (activity levels)
- Set goals
- Develop a targeted treatment plan
- Determine whether a consultation is needed

Evaluation of the patient

- Medical history
- Physical exam including pain assessment
- Review of prior work up, diagnostic tests, prior treatment
- Document the nature, intensity, location of pain, effect of pain on physical and psychological function
- History of substance abuse

Risk stratification

10 Principles of universal precautions

1. Diagnosis with appropriate differential
2. Psychological assessment including risk of addictive disorders
3. Informed consent (verbal or written/signed)
4. Treatment agreement (verbal or written/signed)
5. Pre-/post-intervention assessment of pain level and function
6. Appropriate trial of opioid therapy adjunctive medication
7. Reassessment of pain score and level of function
8. Regularly assess the "Four A's" of pain medicine: *Analgesia, Activity, Adverse Reactions, and Aberrant Behavior*
9. Periodically review pain and comorbidity diagnoses, including addictive disorders
10. Documentation

Gourlay DL, Heit HA. *Pain Med.* 2009;10(Suppl 2):S115-123.
Gourlay DL, et al. *Pain Med.* 2005;6(2):107-112.

Risk factors for aberrant behaviors/harm

Biological	Psychiatric	Social
<p>Age ≤ 45 years</p> <p>Gender</p> <p>Family history of prescription drug or alcohol abuse</p> <p>Cigarette smoking</p>	<p>Substance use disorder</p> <p>Preadolescent sexual abuse (in women)</p> <p>Major psychiatric disorder (eg, personality disorder, anxiety or depressive disorder, bipolar disorder)</p>	<p>Prior legal problems</p> <p>History of motor vehicle accidents</p> <p>Poor family support</p> <p>Involvement in a problematic subculture</p>

Katz NP, et al. *Clin J Pain*. 2007;23(2):103-118. Manchikanti L, et al. *J Opioid Manag*. 2007;3(2):89-100. Webster LR, Webster RM. *Pain Med*. 2005;6(6):432-442.

Opioid risk assessment and guidance

- Questionnaires
 - Current Opioid Misuse Measure (COMM)
 - Diagnosis, Intractability, Risk, and Efficacy (DIRE)
 - Opioid Risk Tool (ORT)
 - Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R)
 - Screening Instrument for Substance Abuse Potential (SISAP)
- Opioid treatment agreement
- Reviewing PDMP information
- Urine drug testing (UDT)
- Abuse deterrent opioid formulations
- Ongoing patient monitoring

Butler SF, et al. *J Pain*. 2008;9(4):360-372. Katz NP, et al. *Clin J Pain*. 2007;23(2):103-118. Webster LR, Webster RM. *Pain Med*. 2005;6(6):432-442. Manchikanti L, et al. *J Opioid Manag*. 2007;3(2):89-100.

Opioid Risk Tool

Mark each box that applies

	Female	Male
1. Family history of substance abuse		
Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Prescription drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
2. Personal history of substance abuse		
Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
3. Age (mark box if between 16 and 45 years)	<input type="checkbox"/> 1	<input type="checkbox"/> 1
4. History of preadolescent sexual abuse	<input type="checkbox"/> 3	<input type="checkbox"/> 0
5. Psychological disease		
ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Scoring totals	_____	_____

Administration

☐ Initial visit

☐ Prior to opioid therapy

Scoring

☐ 0-3 (6%): low risk

☐ 4-7 (28%): moderate risk

☐ ≥8 (91%): high risk

Percentages indicate proportion of classified patients who exhibited an aberrant behavior

ADD, attention-deficit disorder; OCD, obsessive-compulsive disorder. Webster LR, Webster RM. *Pain Med*. 2005;6(6):432-442.

Screener and Opioid Assessment for Patients with Pain (SOAPP®) Short Form

Please answer the questions below using the following scale:
0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

- How often do you have mood swings?
- How often do you smoke a cigarette within an hour after you wake up?
- How often have you taken medication other than the way that it was prescribed?
- How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?
- How often, in your lifetime, have you had legal problems or been arrested?

Please include any additional information you wish about the above answers. Thank you.

To score the SOAPP-SF, add ratings of all questions. A score of 4 or higher on this 5-question version of the SOAPP-SF is considered high risk.

Score = 3

Multiple versions of the SOAPP are available at PainEDU.org

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Stratify risk

Low risk

No past/current history of substance abuse

Noncontributory family history of substance abuse

No major or untreated psychological disorder

→

Moderate risk

History of treated substance abuse

Significant family history of substance abuse

Past/comorbid psychological disorder

→

High risk

Active substance abuse

Active addiction

Major untreated psychological disorder

Significant risk to self and practitioner

Webster LR, Webster RM. *Pain Med*. 2005;6(6):432-442.

Principles for responsible prescribing

- I have resolved key points before initiating opioid therapy
 - Diagnosis established and opioid treatment plan developed
 - Established level of risk
 - I can treat this patient alone/I need to enlist other consultants to co-manage this patient (pain or addiction specialists)
- I have considered nonopioid modalities
 - Pain rehabilitation program
 - Behavioral strategies
 - Non-invasive and interventional techniques

Patient background and personal history influences risk of death from overdose with prescription opioid analgesics

Category	Risk Factor
Demographics ¹	<ul style="list-style-type: none"> Gender (male?) Between the ages of 45-54 years White or Native American
Socioeconomics ¹	<ul style="list-style-type: none"> Residing in a rural area Low income Covered by Medicaid
Substance abuse ²	<ul style="list-style-type: none"> Alcohol consumption Long-term opioid use Recent medical care for opioid poisoning or intoxication Recent released prison or from a mandatory abstinence or drug detox program History of substance abuse³
Prescription drug use	<ul style="list-style-type: none"> Filling of multiple prescriptions (doctor shopping)¹ Concomitant use of CNS depressants such as benzodiazepines and tricyclic antidepressants³
Other	<ul style="list-style-type: none"> Military veteran⁴ Mental health problem¹

¹CDC policy document: Overdose and ER Interventions Payors
²SAMHSA Opioid Overdose Toolkit, HHS Publication No. (SMA) 13-4742, Rockville, MD: SAMHSA, 2013.
³Webster LR, et al. *Pain Med* 2011;12 Suppl 2:S26-S35.
⁴Seal KH, et al. *J Am Med Assoc*. 2012;307:840-847.

Medical history influences risk of overdose

- The diagnosis of any of the following medical conditions increases the risk of overdose¹
 - Sleep apnea
 - Chronic obstructive pulmonary disease
 - Asthma
 - Chronic kidney disease
 - Liver function abnormalities
 - HIV infection²
- Risk is also influenced by
 - Post traumatic stress syndrome
 - Other psychological or psychiatric conditions

¹Zoller B, et al. *Pain Med*. 2014;15:1911-28.
²Seal KH, et al. *J Am Med Assoc*. 2012;307:840-847.

Risk of opioid use disorder based on patient behaviors

Lower Risk

- Stable pattern of medication use
- Improvement in overall function while on medication
- Expresses concerns about side effects
 - Has leftover medication
- Does not seek additional opioids once adequate analgesia is achieved

Higher Risk

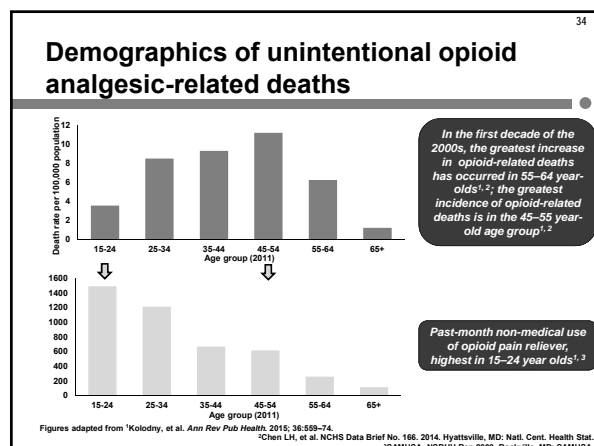
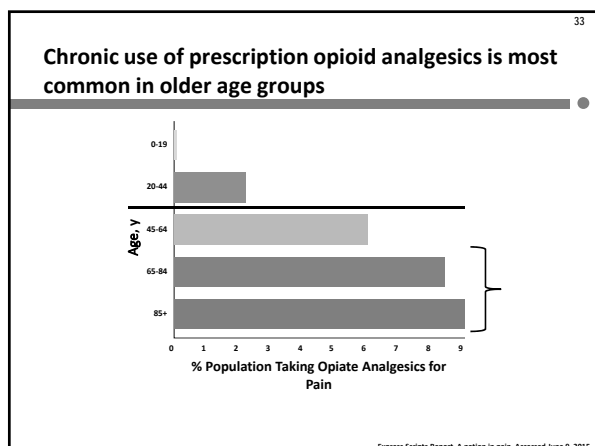
- Loss of control with medication
- Decrease in overall function while on medication
- Ignores persistent adverse effects
- Does not follow treatment plan
- Does not have leftover medication
- Continues to seek opioids despite adequate analgesia

¹Gunderson EW et al. *Subst Abuse*. 2009;30(3):253-260.

Risk of overdose for bystanders: children and teenagers

- Young children and teenagers are exposed to prescription opioids that are prescribed for others, most commonly at home¹
- A RADARS* study (2003–2006) found that nearly all exposures to prescription opioids in children <6 years old involved ingestion (99%) and occurred in the home (92%)¹
 - In 9,179 children, exposures were associated with 8 deaths
- A 10-year study of pediatric poisonings compared against adult prescriptions found adult medications significantly associated with exposures and poisonings in children of all ages with the strongest association for opioids²
 - Across medications, the greatest risk was among children <5 years old, then 13–19 year-olds
 - Rates of ED visits were highest for hypoglycemics (60.1%) but serious injuries and hospitalizations occurred most frequently with opioids (26.8%, 35.2%, respectively)
- Every day, 2,500 US adolescents, aged 12–17, abuse a prescription pain reliever for the first time³
 - Past-month non-medical use of opioid pain relievers highest in 15–24 year-olds⁴

¹Bailey JE, et al. *Ann. Emerg Med*. 2009;53:419-24.
²Burgin RL, et al. *Pediatrics*. 2013;132:18-27.
³http://www.asam.org/docs/default-source/advocacy/opioid-addiction-overview-facts-figure.pdf
⁴Kolodny A, et al. *Ann Rev Public Health* 2015; 36:559-74.



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²⁴WHO. Community management of opioid overdose. http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/.

²SAMHSA Opioid Overdose Toolkit. HHS Publication No. (SMA) 13-4742. Rockville, MD: SAMHSA 2013; ³Franklin. *Neurology*. 2014. 83:1277-1284.

⁴Yang Z, et al. *J Pain*. 2015;16(5):445-453; ⁵Yokell MA, et al. *JAMA Intern Med*. 2014;174(12):2034-2037; ⁶Webster LR, et al. *Pain Med*. 2011;12 Suppl 2:S26-S35; ⁷Johnson SJ. *Pain Treatment Topics*. June 2007. <http://paincommunity.org/blog/wp-content/uploads/Opioids-Respiratory-Dysfunction.pdf>. Accessed Jan 2, 2015.

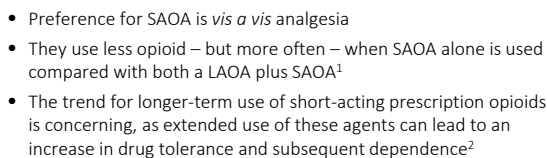
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- | Drug | Market Share,* % |
|--|------------------|
| Vicodin® (hydrocodone with acetaminophen) | 46.1 |
| Ultram® (tramadol) | 14.7 |
| Percocet® (oxycodone with acetaminophen) | 13.6 |
| OxyContin® (oxycodone) | 8.3 |
| Tylenol® with codeine (acetaminophen with codeine) | 3.8 |

Table adapted from (1)

²Arnoff C and Silvershein D. *Mayo Clin Proc.* 2009;84(7):602–61.

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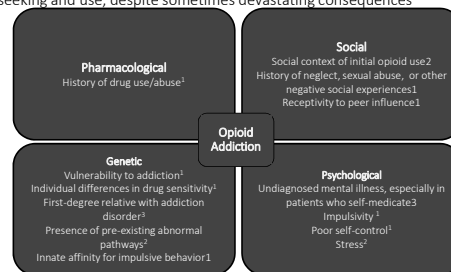


¹Argoff CE, Silvershein DL. Mayo Clin Proc. 2009;84(7):602-612.

²Express Scripts Report. A nation in pain. Accessed June 2015.

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- Addiction* can include dependence but is distinguished by compulsive drug seeking and use, despite sometimes devastating consequences

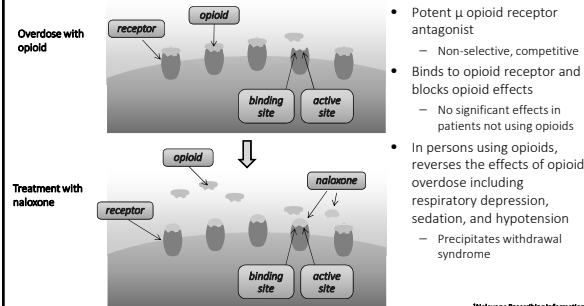


*According to National Institute on Drug Abuse (NIDA): <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body>
 †<http://www.futuresofpalmbeach.com/drug-abuse/contributing-factors/>; ‡Kosten TR et al. *Science & Practice Perspectives*. 2002;13-20; <http://www.mtngs.com/opiates/effects>

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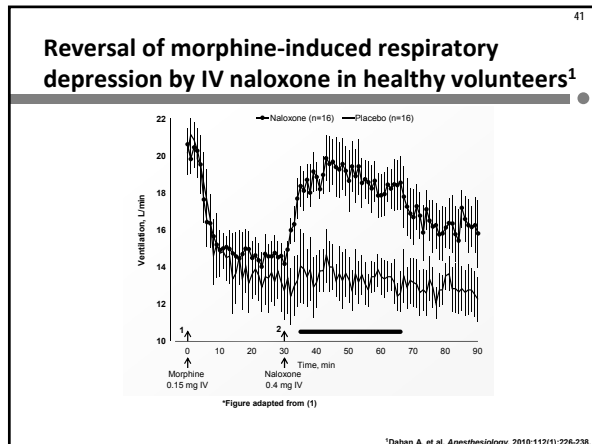
- Synthetic congener of oxymorphone





Figures adapted from Naloxone and Overdose Prevention Program of Rhode Island
<http://www.noperi.org/ems.html>.

²Naloxone Prescribing Information
<http://www.drugs.com/pro/naloxone.htm>



- ### Considerations for opioid analgesics in pain management: implications for risk of overdose
- Variability in dose requirements
 - Variation in susceptibility to side effects
 - Varying potency among opioids (opioid equivalence)
 - Can result in differences in side effect profiles
 - These differences can be genetic in origin
 - Presence of co-morbidities
 - Depression, may be underdiagnosed
 - Insomnia, very common in patients with chronic pain
 - Dose regimens and tolerance
 - Variability in outcomes (starting pain intensity and degree of relief with opioid) measurements
- Interpatient variability
- ¹Nadeau S. *Neurology*. 2015; 85:646-65

Naloxone in clinical practice

Naloxone has been approved in the US for reversal of the effects of opioid overdose since 1971

Injection indicated for complete or partial reversal of opioid depression¹

Dosing initiated at 0.4-2 mg and repeated at 2-3 min intervals until patient responds with adequate spontaneous breathing.¹

Rapidly distributed throughout the body¹:

C_{max} : 1.07 ng/mL²

T_{max} : 20 min²

Duration of effect 30-90 min; further doses may be required if patient has taken long-acting opioids.

$t_{1/2}$: 30-81 min¹

Well tolerated but can precipitate opioid withdrawal syndrome in patients with opioid dependence

Body aches	Runny nose
Diarrhea	Shaking
Fever	Sneezing
Irritability	Sweating
Increased blood pressure	Tachycardia
Nausea/vomiting	Yawning
Piloerection	Weakness

¹Naloxone Prescribing Information <http://www.drugs.com/pro/naloxone.html>

²Evzio Prescribing Information

- ### Clinical interface between pain and addiction
- Pain and addiction are complex; both have strong behavioral components¹
 - Both the addiction and pain systems are dependent on opioid agonist activity at the mu-receptor²
 - Both the treatment of pain with opioid analgesics and abuse of opioids interact at the brain-reward center in the limbic system, which leads to feelings of pleasure or reward³
 - Genetic data suggest that pain, opioid analgesia, and opioid addiction may share similar patterns of gene expression¹
 - The goals of pain treatment are to reduce pain and suffering, enhance quality of life, and increase the ability to function, which requires achieving a balance between treating the pain and avoiding diversion and abuse⁴
 - Developing and following a treatment plan, and monitoring behaviors of patients treated with opioid analgesics can help achieve treatment goals^{4,5}
- ¹ASAM *Essentials of Addiction Medicine*. 2015. (Chapter 9):535-540.
²Trescott AM, et al. *Pain Physician*. 2008;11:513-5163.
³Edwards S, Koob GF. *Future Neurol*. 2010;5(3):363-401.
⁴Pasick SD, Kirsch KL. *Exp Clin Psychopharm*. 2008;16(5):400-404.
⁵Gunderson EW et al. *Subst Abuse*. 2009;30:253-260.

- ### Criteria for substance use disorder diagnosis:¹ patient must meet at least 2 criteria
- Continuing to use opioids despite negative personal consequences
 - Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
 - Recurrent use of opioids in physically hazardous situations
 - Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
 - Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount
 - Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal
 - Using greater amounts or using over a longer time period than intended
 - Persistent desire or unsuccessful efforts to cut down or control opioid use
 - Spending a lot of time obtaining, using, or recovering from using opioids
 - Stopping or reducing important social, occupational, or recreational activities due to opioid use
 - Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
 - Craving or a strong desire to use opioids
- 2-3 criteria, mild
- 4-5 criteria, moderate
- 6-7 criteria, severe
- ¹American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Washington, DC: American Psychiatric Association.

Opioid overmedication and potential for overdose¹

OVERMEDICATION

Unusual sleepiness or drowsiness Mental confusion Slurred speech Slow or shallow breathing	Pinpoint pupils (meiosis) Slowed heartbeat Low blood pressure Difficulty waking the person
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OVERDOSE

Face clammy and pale Body is limp Fingernails and lips tinged blue or purple	Vomiting/gurgling noises Respiration and/or heartbeat very slow or stopped Cannot be awakened Death rattle
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¹SAMHSA Opioid Overdose Toolkit.
 HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

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Strategies for prevention of overdose

- Education of drug users¹
- Family support groups¹
- Motivational post-overdose interviews¹
- Supervised injecting rooms¹
- Provide naloxone for home use¹
- Encourage prescribers to use state Prescription Drug Monitoring Program (PDMPs)²
- Assessment of patient: Obtain history of the patient's past drug use²
- In emergency situations, the physician should prescribe the smallest possible quantity (typically not exceeding 3 days' supply) and arrange for return visit the next day²

¹SAMHSA Opioid Overdose Toolkit. HHS Publication No. (SMA) 13-4742, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

²Sporer KA. Brit. Med Journal. 2003; 326:442-444.

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Mitigation of overdose risk in people with pain

- Risk exists for both people with pain, and people with substance use disorders
 - And, of course, in those with both
- There is a recent trend toward increased prescribing of naloxone for use in case of unintentional overdose
- Much of the focus in this area has been for people without a legitimate medical need for opioids as part of a pain care plan
- When should naloxone prescribing be considered for people with pain who use opioids for pain relief?

INTERVENTIONS IMPLEMENTED BY PATIENTS AT RISK FOR OVERDOSE¹

- Take special precautions with new patients
- Educate patients and obtain informed consent
- Monitor patient's response to treatment
- Decide when and whether to end opioid
- Consider prescribing naloxone for patients

¹SAMHSA Opioid Overdose Toolkit. HHS Publication No. (SMA) 13-4742, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

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Recommendations for safe and effective use of opioid analgesics for chronic noncancer pain¹

1. Opioid analgesic treatment agreement
2. Screen for prior or current substance abuse/misuse (alcohol, illicit drugs, heavy tobacco use)
3. Screen for depression
4. Prudent use of random urine drug screening (diversion, non prescribed drugs)
5. Do not use concomitant sedative-hypnotics or benzodiazepines
6. Track pain and function to recognize tolerance and track effectiveness
7. Track daily MED using an online dosing calculator
8. Seek help if MED exceeds 80-120 mg and pain and function have not substantially improved
9. Use the state Prescription Drug Monitoring Program to monitor all sources of controlled substances

¹Franklin GM. Neurology. 2014;83:1277-1284.

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Key requirements of a naloxone policy¹

1. Widespread access to naloxone for anyone who may witness an opioid overdose
2. Liability limits for administering naloxone
3. Protection against legal action
4. Education about when and how to use naloxone
5. Naloxone delivery system that is easy-to-use, portable, and inexpensive

¹Network for Public Health Law Naloxone Access Report, May 8, 2015. https://www.networkforphl.org/_asset/.../network-naloxone-10-4.pdf. Accessed June 30, 2015.

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What is the "Good Samaritan Policy"?

- Provides immunity to people administering naloxone or obtaining treatment for someone experiencing an overdose
- Promotes responsible action by people reluctant to act due to legal concerns
- Several states have now amended laws to encourage "Good Samaritans" to seek medical assistance

¹Network for Public Health Law Naloxone Access Report, May 8, 2015. https://www.networkforphl.org/_asset/.../network-naloxone-10-4.pdf. Accessed June 30, 2015.

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Putting naloxone into the hands of bystanders (overdose witnesses)

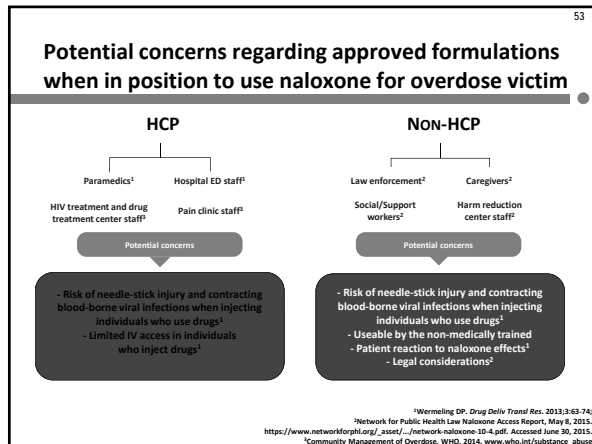
THIRD-PARTY PRESCRIBING

Several states have introduced legislation allowing physicians to prescribe naloxone to a third party who can give naloxone when indicated¹

STANDING ORDER

In some cases, physicians can issue a standing order allowing non-medical personnel to distribute naloxone to those they consider at risk for possible overdose¹

¹Network for Public Health Law Naloxone Access Report, May 8, 2015. https://www.networkforphl.org/_asset/.../network-naloxone-10-4.pdf. Accessed June 30, 2015.



- ### All Prescribers Play an Active Role in Reducing the Risks Associated With Opioids
- When opioids are being considered as part of a chronic pain treatment plan:
 - Establish diagnosis
 - History and physical
 - Relevant diagnostic tests
 - Complete an appropriate risk assessment PRIOR to prescribing
 - Monitor the patient regularly on an ongoing basis
 - Recognize that all patients are at risk
 - Prescribe opioids as part of a multimodal treatment regimen
- McCarberg BH. *Postgrad Med.* 2011;123(2):119-130; Brennan MJ, et al. *PM R.* 2010;2(6):544-558.

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- ### Conclusions
- Opioid analgesics remain among the most commonly prescribed medications for people experiencing chronic pain.
 - Among the many adverse effects of chronic opioid therapy is the potential for misuse, abuse and unintentional overdose resulting in significant morbidity including death.
 - Multiple practical steps can be instituted by the prescriber to help reduce the risk of misuse and abuse as well as reduce the risk of unintentional overdose.