E·QUAL | EMERGENCY QUALITY NETWORK

Opioid Initiative Wave I –
Guidelines

Presenter

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Why Guidelines for Pain?

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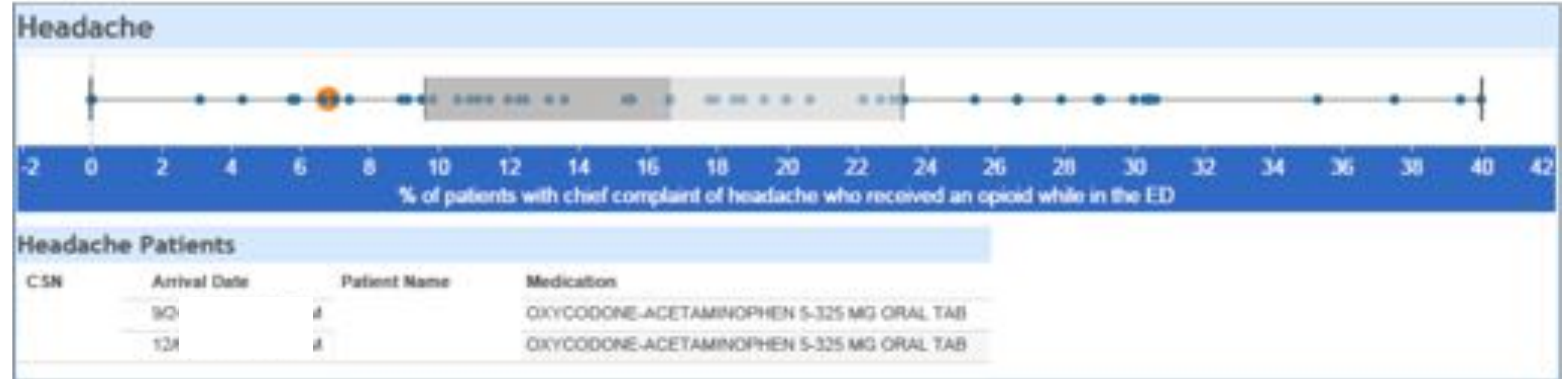
Financial Disclosures

No Disclosures

EFFECTIVELY AND RESPONSIBLY
MANAGE ^ CHRONIC PAIN
ACUTE &

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES



Headache Patients

CSN	Arrival Date	Patient Name	Medication
	9/2 d		OXYCODONE-ACETAMINOPHEN 5-325 MG ORAL TAB
	12/ d		OXYCODONE-ACETAMINOPHEN 5-325 MG ORAL TAB

Back Pain

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75

% of patients with chief complaint of back pain who received an opioid while in the ED

Back Pain Patients

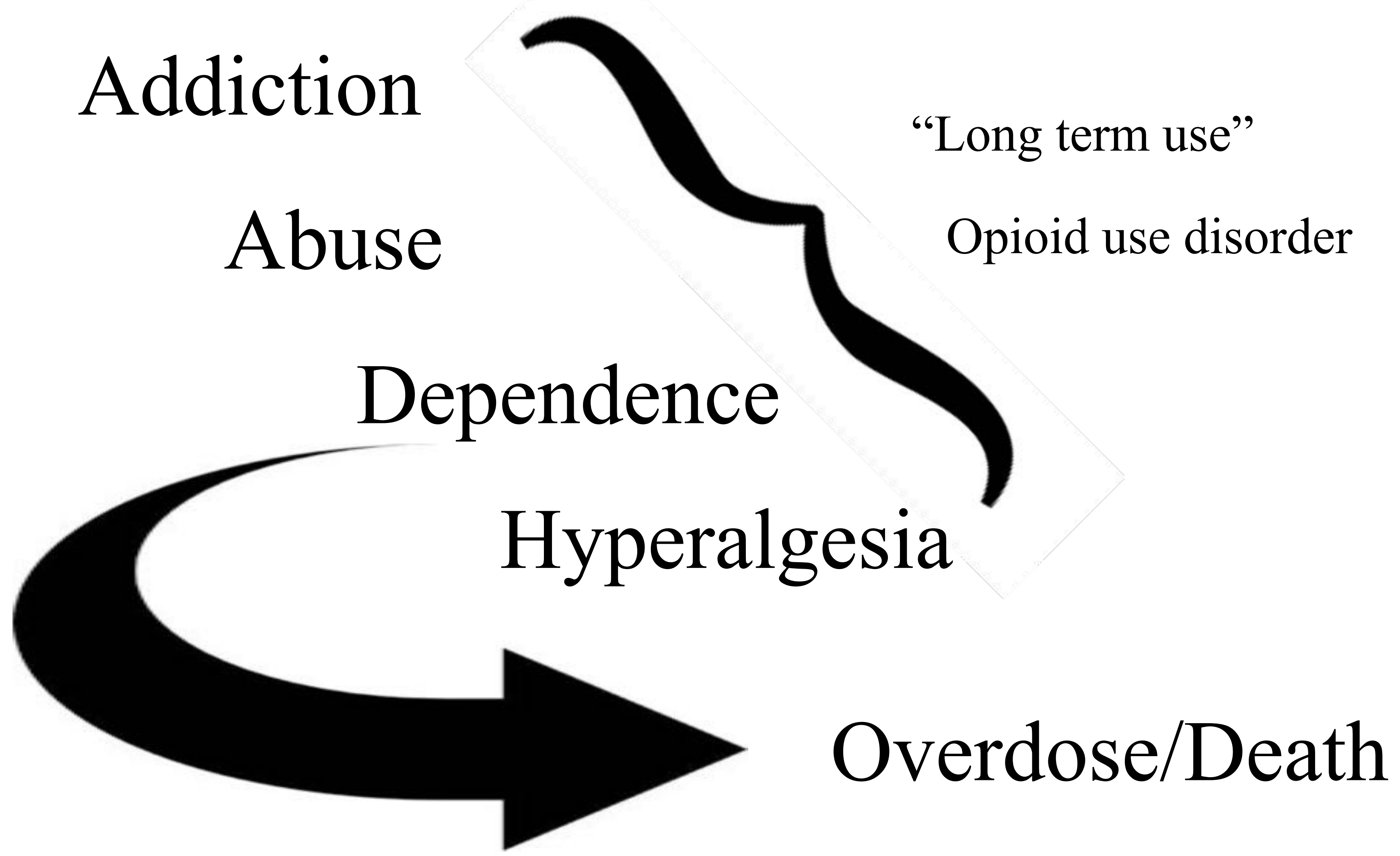
CSN	Arrival Date	Patient Name	Medication
	3/ M		HYDROMORPHONE INJECTION ORDERABLE
	1/		MORPHINE INJ ORDERABLE
	12/ PM		MORPHINE INJ ORDERABLE
	12/ M		OXYCODONE-ACETAMINOPHEN 5-325 MG ORAL TAB
	11/ PM		METHADONE 10 MG ORAL TAB
	10/ PM		OXYCODONE-ACETAMINOPHEN 5-325 MG ORAL TAB
	10/ PM		OXYCODONE-ACETAMINOPHEN 5-325 MG ORAL TAB
	7/ AM		OXYCODONE-ACETAMINOPHEN 5-325 MG ORAL TAB

Why Guidelines?

Improve consistency (reduce variability) of pain management and opioid use

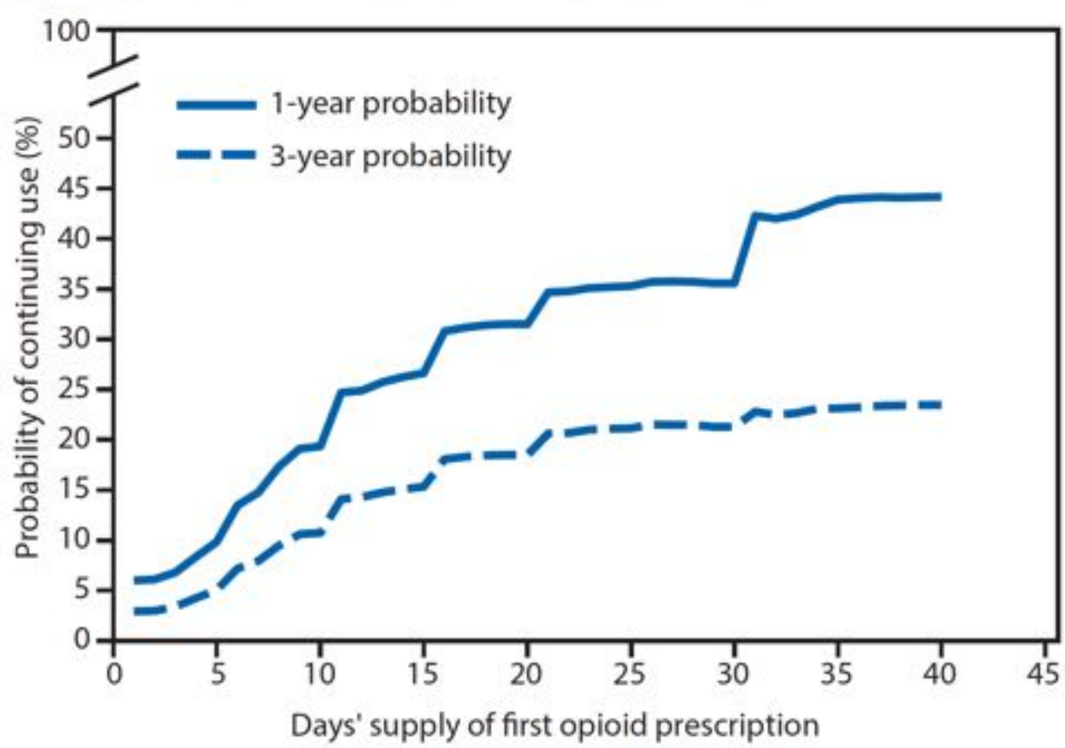
Reduce harm of opioid prescribing, while maintaining appropriate use

Consequences of opioid use



Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

Keep Opioid Naïve Patients Opioid Naïve (as long as possible)

Washington Emergency Department Opioid Prescribing Guidelines

1. One medical provider should provide all opioids to treat a patient's chronic pain.

2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.

3. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.

4. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.

5. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.

6. EDs are encouraged to share the ED visit history of patients with other emergency physicians who are treating the patient using an Emergency Department Information Exchange (EDIE) system.

7. Physicians should send patient pain agreements to local EDs and work to include a plan for pain treatment in the ED.

8. Prescriptions for controlled substances from the ED should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.

9. EDs are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.

10. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.

11. EDs should maintain a list of clinics that provide primary care for patients of all payer types.

12. EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.

13. The administration of Demerol® (Meperidine) in the ED is discouraged.

14. For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary opioid prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.

15. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

16. ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

17. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.

Ohio Guideline for the Management of Acute Pain Outside of Emergency Departments

Preface: This guideline provides a general approach to the outpatient management of acute pain. It is not intended to take the place of clinician judgement, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient. This guideline is the result of the work from the Governor's Cabinet Opiate Action Team (GCOAT) and the workgroup on Opioids and Other Controlled Substances (OOCS).

Introduction

In 2014, 2,482 individuals in Ohio died from an unintentional opioid-related overdose – more than a four-fold increase in 10 years[1]. Unintentional opioid overdose has become one of the leading causes of injury-related death in Ohio over the past decade. To respond to this challenge, public health and health care leaders have committed to helping healthcare providers better serve their patients with pain, while reducing the potential for overdose and death. As part of the Governor's Cabinet Opiate Action Team (GCOAT), the workgroup on Opioids and Other Controlled Substances (OOCS) was charged with developing guidelines for the safe, appropriate and effective prescribing of self-administered medications for pain. The two previously released guidelines are:

- Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances Prescribing Guidelines [Released 2012; Revised 2014]
- Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain 80mg of a Morphine Equivalent Dose (MED) "Trigger Point" [Released 2013]

Purpose

This third guideline is focused on the management of acute pain and the prescribing of self-administered medications for acute pain, delineating a standardized process that includes **key checkpoints** for the clinician to pause and take additional factors into consideration.

Definition of Acute Pain

For this guideline, acute pain is defined as pain that normally fades with healing, is related to tissue damage and significantly alters a patient's typical function. Acute pain is expected to resolve within days to weeks; pain present at 12 weeks is considered chronic and should be treated accordingly. This guideline may not apply to acute pain resulting from exacerbations of underlying chronic conditions.

Assessment and Diagnosis of Patient Presenting with Pain

For assessing patients presenting with acute pain, in addition to a proper medical history and physical exam, initial considerations should include:

- Location, intensity and severity of the pain and associated symptoms
- Quality of pain e.g. somatic (sharp or stabbing), visceral (ache or pressure) and neuropathic pain (burning, tingling or radiating)[2]
- Psychological factors, including personal and/or family history of substance use disorder

A specific diagnosis should be made, when appropriate, to facilitate the use of an evidence-based approach to treatment.

Develop a Plan

Upon determining the symptoms fit the definition of acute pain, both the provider and patient should discuss the risks/benefits of both pharmacologic and non-pharmacologic therapy. The provider should educate and develop a treatment plan together with the patient that includes[3]:

- Measureable goals for the reduction of pain
- Use of both non-pharmacologic and pharmacologic therapies, with a clear path for progression of treatment
- Mutually understood expectations for the degree and the duration of the pain during therapy
- **Goal: Improvement of function to baseline or pre-injury status as opposed to complete resolution of pain**

Treatment of Acute Pain

While these guidelines provide a pathway for the management of acute pain, not every patient will need each option and care should be individualized.

Non-Pharmacologic Treatment

Non-pharmacologic therapies should be considered as first-line therapy for acute pain unless the natural history of the cause of pain or clinical judgment warrants a different approach. These therapies often reduce pain with fewer side effects and can be used in combination with non-opioid medications to increase likelihood of success. Examples may include, but are not limited to:

- Ice, heat, positioning, bracing, wrapping, splints, stretching and directed exercise often available through physical therapy
- Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, manipulation, and osteopathic neuromuscular care
- Biofeedback and hypnotherapy

Non-Opioid Pharmacologic Treatment

Non-opioid medications should be used with non-pharmacologic therapy. When initiating pharmacologic therapy, patients should be informed on proper use of medication, importance of maintaining other therapies and expectation for duration and degree of symptom improvement. Treatment options, by the quality of pain, are listed below.

New York City Department of Health and Mental Hygiene

New York City Emergency Department Discharge Opioid Prescribing Guidelines

Note: These guidelines do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while in the ED.

In the management of patients with acute or chronic non-cancer pain discharged from an emergency department,

1. Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.
2. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.
3. Prescribe no more than a short course of opioid analgesics for acute pain. Most patients require no more than three days.
4. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients' controlled substance prescription history.
5. Avoid initiating treatment with long-acting or extended-release opioid analgesics.
6. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.
7. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.
8. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one-to two-day supply.
9. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/addiction, as well as safe storage and proper disposal of unused medications.

New York City to Restrict Prescription Painkillers in Public Hospitals' Emergency Rooms

By ANEMONA HARTOCOLLIS JAN. 10, 2013

Mayor Michael R. Bloomberg, with the health commissioner, Dr. Thomas A. Farley, at the lectern, and other health officials and doctors, announced new measures to stop the abuse of some pain drugs.

Ozier Muhammad/The New York Times

Promoting Health Department Opioid-Prescribing Guidelines for New York City Emergency Departments: A Qualitative Evaluation

Frederick W. Nagel, MD, MPH; Jessica A. Kattan, MD, MPH; Shivani Mantha, BA; Lewis S. Nelson, MD; Hillary V. Kunins, MD, MPH, MS; Denise Paone, EdD

ABSTRACT

To address the epidemic of opioid misuse and overdose, the New York City Department of Health and Mental Hygiene partnered with an expert panel of emergency medicine physicians to develop voluntary guidelines for judicious prescribing of opioids upon discharge from an emergency department. A qualitative evaluation of the guidelines was conducted using semistructured interviews with emergency department directors and providers. The guidelines were widely supported by respondents and cited as helpful in easing difficult negotiations with patients requesting opioids. Involvement of the expert panel in development of guidelines was particularly valuable in ensuring their credibility. Health departments should consider partnering with emergency physicians to promote the public health goal of judicious opioid prescribing.

KEY WORDS: emergency medicine, opioid-related disorders, policy making, public health

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KEY WORDS: emergency medicine, opioid-related disorders, policy making, public health

Ease difficult negotiations with patients requesting opioids.

“Put the blame elsewhere”

“The pressure to prescribe goes away.”

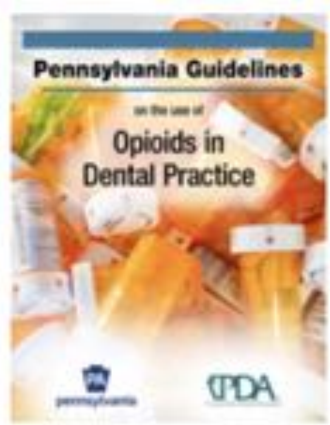
The posters helped communicate the guidelines’ content and intent.

“Disarm potential conflict”

Despite positive experiences with the guidelines, more than half of providers reported no change to their prescribing behavior.

Prescribing Guidelines for Pennsylvania
TREATING
CHRONIC NON-CANCER PAIN

Pennsylvania Guidelines
Emergency Department (ED)
Pain Treatment Guidelines


Pennsylvania Guidelines
on the use of
Opioids in
Dental Practice
pennsylvania
PDA

Prescribing Guidelines for Pennsylvania
OPIOID
DISPENSING
GUIDELINES

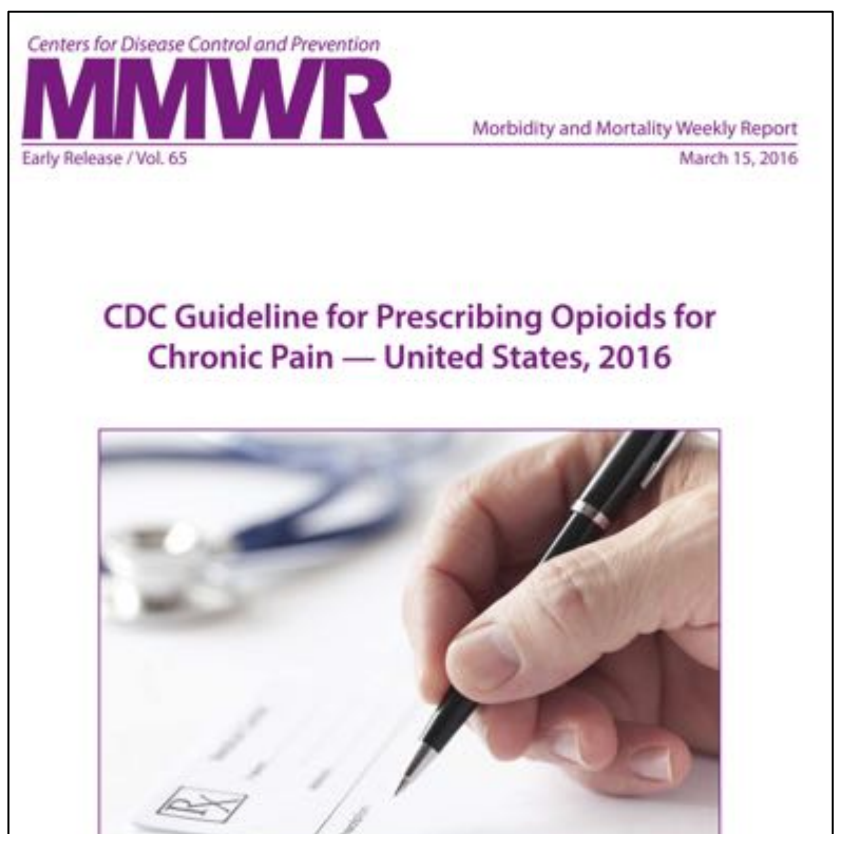
Prescribing Guidelines for Pennsylvania
OBSTETRICS &
GYNECOLOGY
OPIOID PRESCRIBING
GUIDELINES

Prescribing Guidelines for Pennsylvania
GERIATRIC PAIN
Opioid Use and Safe Prescribing

Prescribing Guidelines for Pennsylvania
USE OF ADDICTION TREATMENT MEDICATIONS
IN THE TREATMENT OF PREGNANT PATIENTS
WITH OPIOID USE DISORDER

Prescribing Guidelines for Pennsylvania
SAFE PRESCRIBING BENZODIAZEPINES
FOR
ACUTE TREATMENT
OF
ANXIETY & INSOMNIA

Prescribing Guidelines for Pennsylvania
The Safe Prescribing of Opioids in
Orthopedics and Sports Medicine



Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

CDC Guidelines

1 OPIOIDS ARE NOT FIRST-LINE THERAPY

Nonpharmacologic therapy and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2 ESTABLISH GOALS FOR PAIN AND FUNCTION

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

3 DISCUSS RISKS AND BENEFITS

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING

When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

5 USE THE LOWEST EFFECTIVE DOSE

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 **morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Immediate-release opioids: faster acting medication with a shorter duration of pain-relieving action

Extended release opioids: slower acting medication with a longer duration of pain-relieving action

Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 EVALUATE BENEFITS AND HARMS FREQUENTLY

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

8 USE STRATEGIES TO MITIGATE RISK

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent **benzodiazepine** use, are present.

9 REVIEW PDMP DATA

Clinicians should review the patient's history of controlled substance prescriptions using state **prescription drug monitoring program (PDMP)** data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 USE URINE DRUG TESTING

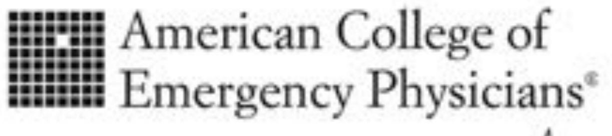
When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 OFFER TREATMENT FOR OPIOID USE DISORDER

Clinicians should offer or arrange evidence-based treatment (usually **medication-assisted treatment** with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.



POLICY STATEMENT

Approved April 2017

Optimizing the Treatment of Acute Pain in the Emergency Department

Approved by the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society of Emergency Medicine Physician Assistants August 2017

Approved April 2017

Replaces 2009 policy titled "Optimizing the Treatment of Pain in Patients with Acute Presentations" rescinded April 2017

A joint policy statement of the American College of Emergency Physicians, the American Academy of Emergency Nurse Practitioners, the Emergency Nurses Association, and the Society of Emergency Medicine Physician Assistants

The American College of Emergency Physicians seeks to improve acute pain management for patients in the emergency department (ED) and recognizes the need for prompt, safe, and effective pain management. **Although a very important topic, treatment of patients with chronic pain, especially those receiving hospice, palliative or end-of-life care, is beyond the scope of this document.**

Optimal acute pain management is patient-specific and pain syndrome-targeted when feasible, using a multimodal approach that includes pharmacological and non-pharmacological interventions. Base the assessment of pain and need for therapy on an overall accounting of patient status, including functional assessment, rather than solely on patient reported pain scores.

Acute Pain Management in the ED

Pharmacologic Treatments:

- Pharmacologic treatment of many_acutely painful conditions should optimally begin with a non-opioid agent.
- Choose non-steroidal anti-inflammatory drugs (NSAIDs) based on their analgesic ceiling dose (which is lower than the anti-inflammatory maximal doses) and prescribe at the lowest effective dose for the shortest expected duration to avoid complications. Use NSAIDs with added caution in those with pre-existing renal insufficiency, heart failure, a predisposition to gastrointestinal hemorrhage, and in elderly patients.
- Oral (or rectal) acetaminophen is a good initial analgesic for mild-moderate pain. Intravenous acetaminophen (APAP) has similar effects as

Non-pharmacologic

Regional anesthesia

Subdissociative dose ketamine

Transdermal lidocaine

University Hospital Adult Emergency Medicine Treatment of Acute Pain Guideline

- Alternative therapies should be considered if there are contraindications to first line recommendations
- Consider next line therapies in a stepwise manner if pain persists 30 minutes after an IV dose **OR** 60 minutes after a PO dose
- Other than in the treatment of severe acute pain, the oral route is the preferred route of administration of most analgesic drugs

Abdominal Pain

First Line	Second Line	Third Line	Adjunctive Therapy	Discharge
Undifferentiated abdominal pain Acetaminophen 975 mg PO **AND/OR** Ibuprofen 400 – 600 mg PO (If patient cannot tolerate PO, ketorolac 15 mg IV) *Spasmodic pain* Dicyclomine 20 mg PO (If patient cannot tolerate PO, dicyclomine 10 mg IV) *Gastroparesis* Metoclopramide 10 mg IV	*Undifferentiated abdominal pain* Ketamine 0.3 mg/kg IV over 15 minutes *Gastroparesis* Haloperidol 5 mg IV **OR** Haloperidol 5 mg IM	Opioid rescue*	*Anti-emetics* Ondansetron 4 mg IV **OR** Ondansetron ODT 4 mg PO **OR** Metoclopramide 10 mg IV *Antacids* Mag hydroxide/aluminum hydroxide/simethicone 1200 mg/1200 mg/120 mg PO **AND/OR** Famotidine 20 mg IV	*Undifferentiated abdominal pain* Acetaminophen 975 mg PO q6H PRN **AND/OR** Ibuprofen 400 mg PO q6H PRN *Spasmodic pain* Dicyclomine 20 mg PO q6H PRN *Gastroparesis* Metoclopramide 10 mg PO q6H PRN

Clinical Pearls:

- Consider underlying etiology of abdominal pain before selecting treatment option (e.g. anticholinergics and opioids counterintuitive in gastroparesis)
- Ketamine: avoid use in patients with severe hypertension or history of psychosis
- NSAIDs: avoid use in third trimester of pregnancy, peptic ulcer disease, history of GI bleed, or active major bleeding
- Provide patient education regarding type of pain, medication choices, and what to expect
- Consider distractions such as music, talking to patient

Dental Pain

First Line	Second Line	Third Line	Adjunctive Therapy	Discharge
Acetaminophen 975 mg PO **AND/OR** Ibuprofen 400 – 600 mg PO (If patient cannot tolerate PO, ketorolac 15 mg IV)	Lidocaine 2% viscous solution – swish and spit	Lidocaine 1% dental block	Apply ice pack to painful area	Acetaminophen 975 mg PO q6H PRN **AND/OR** Ibuprofen 400 – 600 mg PO q6H PRN **AND/OR** Lidocaine 2% viscous solution – swish and spit q3 hours PRN

Clinical Pearls:

- Provide patient education regarding type of pain, medication choices, and what to expect
- Analgesia is a temporizing measure for more definitive treatment
- NSAIDs: avoid use in third trimester of pregnancy, peptic ulcer disease, history of GI bleed, or active major bleeding

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, setting, circumstances or factors, guidelines can and should be tailored to fit individual needs.

Center for Opioid Research and Education

HOME ABOUT ARTICLES GUIDELINES PATIENT EDUCATION

Post-Surgical Opioid Guidelines

We convened a multidisciplinary consortium of physicians, nurses, pharmacists, and patients to develop ideal opioid prescribing patterns after common medical procedures utilizing a modified Delphi approach. Best prescribing practices are listed for post-surgical narcotic naive patients at discharge.

Procedure	Start with this: Acetaminophen 1g PO 8 hours, Ibuprofen 400mg PO 8 hours (unless contraindicated)	If Needed, Opioid Pills Recommended at Discharge: Oxycodone 5 mg tablet*
Laparoscopic cholecystectomy	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets**
Laparoscopic inguinal hernia repair, unilateral	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	12 Tablets
Open inguinal hernia repair, unilateral	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets
Open umbilical hernia repair	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	14 Tablets
Arthroscopic partial meniscectomy	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	8 Tablets
Arthroscopic ACL or PCL repair	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	20 Tablets
Arthroscopic rotator cuff repair	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	20 Tablets
ORIF of the Ankle	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	20 Tablets
Hysterectomy, Open	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	15 Tablets
Hysterectomy, Minimally-Invasive	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets
Uncomplicated Cesarean section	Acetaminophen and/or Ibuprofen (NSAIDs) OR Tramadol	10 Tablets

*While the type of opioid and amount should be individualized to each patient factoring the extent of surgery, patient goals, and clinician recommendation, the pills listed are presented as oxycodone 5mg pill equivalent.

**Oxycodone 5 mg tablet by mouth every 6 to 8 hours for the first 2 days as needed for pain, and then if severe pain persists then may continue taking one tablet every 12 hours for an additional few days.

www.solvethecrisis.org/best-practices

BUPRENORPHINE (BUP) ALGORITHM

MAY 2018

MODERATE TO SEVERE OPIOID WITHDRAWAL

- Use clinical judgement to determine moderate to severe withdrawal.
- If uncertain, use the Clinical Opioid Withdrawal Scale (COWS)
- If using COWS, the score should be ≥ 8 or ≥ 6 with at least one objective sign of withdrawal
- Document: which opioid used, time of last use

COMPLICATING FACTORS

Identify and manage complicating factors prior to proceeding. The only absolute contraindication is allergy to buprenorphine.

Refer to Buprenorphine Guide before dosing buprenorphine for:

- Clinical suspicion of acute liver failure
- ≥ 20 weeks pregnant
- Intoxicated or altered
- Withdrawal precipitated by naloxone
- Taking methadone or long acting opioid
- Chronic pain patients taking prescribed opioids
- Withdrawal symptoms are inconsistent or borderline (COWS of 6-8), or opioid use within 12 hours; consider beginning with a low dose (2-4 mg SL) and titrating every 1-2 hours

PARENTERAL DOSING

- Use if unable to take sublingual (SL)
- Start with 0.3 mg IV/IM buprenorphine; may repeat as needed; switch to SL when tolerated

PRECIPITATED WITHDRAWAL

- Buprenorphine can cause precipitated withdrawal if too large a dose is given too soon after the last opioid use
- The longer the time since last opioid use (> 24 hours) and the more severe the withdrawal symptoms (COWS ≥ 13) the better the response to initial dosing
- Only patients with objective improvement in withdrawal after the 1st dose should receive subsequent dosing
- Worsening after buprenorphine is likely precipitated withdrawal; no further buprenorphine should be administered in the ED; switch to symptomatic treatment

SYMPTOMATIC TREATMENT

- Supportive medications such as clonidine, gabapentin, metoclopramide, low-dose ketamine, acetaminophen, NSAIDs

LOWER TOTAL DOSE OPTION (16 mg)

- Possible lower risk of sedation or precipitated withdrawal
- Some patients will go back into withdrawal in less than 12 hours increasing risk of early dropout
- Buprenorphine prescription or next day follow-up should be available

HIGHER TOTAL DOSE OPTION (24-32 mg)

- Increased magnitude and duration of opioid blockade
- More complete treatment of withdrawal in heavy users
- May suppress craving and protect against overdose (opioid blockade) for 2 days or more
- Use with caution in medically complex patients, older patients, and patients using other sedatives such as alcohol or benzodiazepines

RE-EVALUATION TIME INTERVALS

- The time to SL buprenorphine onset is typically 15 minutes and peak clinical effect is typically within 1 hour
- Re-evaluate patient 1 hour after buprenorphine doses
- Observe for 1 hour after the final dose before discharge

DEA 72 HOUR RULE

- Patients may return to the ED for up to 3 days in a row for repeat doses
- At each visit administer 16 mg SL buprenorphine

FOLLOW-UP

- Goal: follow-up treatment available within 3 days

www.chcf.org

July 15, 2016

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

New Legislation Enacted to Limit Initial Opioid Prescribing to a 7 Day Supply for Acute Pain

TO FURTHER REDUCE OVERPRESCRIBING OF OPIOID MEDICATIONS, EFFECTIVE JULY 22, 2016, INITIAL OPIOID PRESCRIBING FOR ACUTE PAIN IS LIMITED TO A 7 DAY SUPPLY PER NEW YORK STATE PUBLIC HEALTH LAW SECTION 3331, 5. (b), (c). A prac
supply of an opioid medication for
resulting from disease, accidental
practitioner reasonably expects to
NOT include prescribing for chror
hospice or other end-of-life care, c
practices. Upon any subsequent c
issue, in accordance with existing
or new prescription for an opioid.

WORKERS COMP

New Jersey's 5-day opioid prescription bill signed into law

Louise Esola
2/17/2017 1:42:00 PM

SHARE

Prescription Drug Benefits | Prescription Drug Management

In a little less than 90 days doctors, in New Jersey who want to prescribe opioids to their patients for the first time will only be able to prescribe them for five days.

New Jersey Gov. Chris Christie on Wednesday signed into law Assembly Bill 3, which introduced sweeping changes in opioid prescribing and addiction tr
have stated that such laws governing the timi
all licensed doctors, regardless of payer.

The New Jersey law mandates the shortest tir
Mark Pew, senior vice president at Prium, a Du
management firm.

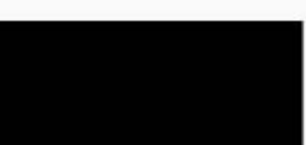
RELATED STORIES

Pilot program aims to help
opioid use

California closed drug form

CVS to cap prescriptions to seven-day supply amid battling opioid epidemic

BY LEONARD GREENE FOLLOW
NEW YORK DAILY NEWS Thursday, September 21, 2017, 8:41 PM



Proposed Medicare Changes to Opioid Prescribing (2019)

Limit prescriptions to 90 morphine milligram equivalents per day

Flag patients as high-risk if taking gabapentin/pregabalin + opioids

Adopt a 7-day limit on initial fills of opioids

Possible (but not guaranteed) exemptions for palliative care, cancer or hospice

Medicare feedback due before March 5, 2018

#CMSpaincontrol

Why Not Guidelines?

They may be wrong:

- **Evidence is limited or subjective**
- **Guideline developers may be conflicted**

They may be misapplied:

- **May not apply to all patients**
- **Interpreted as rules vs guidelines**

Drugs

Risk Evaluation and Mitigation Strategy (REMS) for Opioid Analgesics

Extended-release, long-acting (ER/LA), and immediate-release (IR) opioid analgesics are powerful pain-reducing medications that have both benefits as well as potentially serious risks. The ER/LA Opioid Analgesic REMS, approved on July 9, 2012, is one strategy among multiple national and state efforts to reduce the risk of abuse, misuse, addiction, overdose, and deaths due to prescription opioid analgesics.

The FDA has determined that a REMS is necessary for IR opioid analgesics to ensure that the benefits of these drugs continue to outweigh the risks, and the IR opioid analgesics that are intended to be used in the outpatient setting will be subject to the same REMS requirements as the ER/LA opioid analgesics.

RPC Is Consortium of 24 Companies

Actavis, Inc.	Noven Pharmaceuticals, Inc.
Apotex Inc.	Pernix Therapeutics
Aurolife Pharma, LLC	Perrigo Company plc
Depomed, Inc.	Pfizer, Inc.
Endo Pharmaceuticals Inc.	Purdue Pharma L.P.
Impax Laboratories, Inc.	Ranbaxy Pharmaceuticals, Inc.
Inspirion Delivery Technologies	Rhodes Pharmaceuticals L.P.
Janssen Pharmaceuticals, Inc.	Roxane Laboratories, Inc.
Mallinckrodt Pharmaceuticals	Sandoz, Inc.
Mylan Technologies, Inc.	The PharmaNetwork LLC
Nesher Pharmaceuticals LLC	Upsher-Smith Laboratories, Inc.
Novel Laboratories, Inc.	VistaPharm, Inc.

ER/LA

The Extended-
Analgesics Ri

RISK EVAL

A Risk Evaluation
serious risks asso
(FDA) to ensure that the benefits of a drug outweigh its risks.

The FDA has required a REMS for extended-release and long-acting (ER/LA) opioid analgesics.

Under the conditions specified in this REMS, **prescribers of ER/LA opioid analgesics are strongly encouraged to do all of the following:**

- **Train (Educate Yourself)** - Complete a REMS-compliant education program offered by an accredited provider of continuing education (CE) for your discipline
- **Counsel Your Patients** - Discuss the safe use, serious risks, storage, and disposal of ER/LA opioid analgesics with patients and/or their caregivers every time you prescribe these medicines. Click here for the Patient Counseling Document (PCD)
- **Emphasize Patient and Caregiver Understanding of the Medication Guide** - Stress to patients and their caregivers the importance of reading the Medication Guide that they will receive from their pharmacist every time an ER/LA opioid is dispensed to them

Listing of Accredited CME/CE REMS-Compliant Activities Supported by RPC *UPDATED*

Continuing Education Provider Information

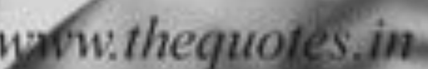
Materials for Healthcare Professionals

Dear DEA-Registered Prescriber Letter

Patient Counseling Document

Be careful about reading health books. You may die of a misprint.

Mark Twain



Thank you.

Questions?
Comments?
Concerns?

Feel free to email me at:
lewis.nelson@rutgers.edu

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