tipSC
Timely Information for Providers in South Carolina

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

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S.O.S. FOR SAFER OPIOID PRESCRIBING

https://schealthviz.sc.edu/tipsc-1/

MONITORING PRACTICES TO PROMOTE SAFER OPIOID USE

SHARE A PATIENT PROVIDER AGREEMENT (PPA) with clearly established boundaries and patient expectations PRIOR to initiating a trial of opioids for chronic non-cancer pain

- A PPA signed by both patient and provider and given to the patient is an important, convenient tool that can also **document patient counseling and education**.
- **Offering a PPA to all patients** regardless of a patient's identified risk of opioid misuse and abuse **reduces stigma** and provides a minimal level of precaution/protection to prescriber and patient.
- There is no standard, validated, or legally binding form of a PPA; **consider inclusion of informed consent** (e.g., potential risks and benefits of an opioid trial, continuation, and discontinuation) **and plan of care** (e.g., goals of care and expectations, rights and responsibilities of provider and patient).

OPTIMIZE PATIENT TREATMENT (DRUG/NON-DRUG) USING A MULTI-DIMENSIONAL RATING SCALE to assess chronic pain, quality of life, and progress toward functional goals

- **The PEG is** a brief multi-functional measure of **P**ain, **E**njoyment of life, and **G**eneral activity **useful at baseline and at regular intervals** to assess and document patient response to treatment.
- **Set realistic expectations** that full pain relief is unlikely **and set individualized goals** that are Achievable, Recovery-related, and Measurable (A.R.M.); e.g., 15 minute daily walk.
- Continue or modify opioid treatment with demonstrated benefit and **discontinue when the risks** of side effects, misuse, addiction, and/or overdose **outweigh the benefit**.
- **Engage family and other key individuals when possible** to support patient-obtained information.

SCREEN FOR APPROPRIATE OPIOID USE AND THE CONTINUED NEED FOR OPIOID THERAPY, including prescription drug monitoring reports (e.g., SCRIPTS Narx Reports)

- **Assess and document risk of opioid misuse** with subjective and objective measures **PRIOR to prescribing**, and individualize level of monitoring and possible co-management to match the identified risk.
- **Review SCRIPTS Narx Reports at baseline and periodically** to help identify potential opioid misuse/abuse and support safe prescribing and dispensing.
- Continue to assess, monitor, and document risk of opioid misuse/abuse (including input from family members and key contacts) since **risk level can change for any patient at any point**.
- **Adjust ongoing monitoring plan** (e.g., SCRIPTS Narx Report Review, frequency of visits, urine drug tests, pill counts) **to match risk level** and co-manage or refer for addiction treatment as needed.

QUICK tipSC

SCRIPTS displays naloxone administration reported by first responders or major health care facilities under the *Integrated Patient Records* section

Guideline recommendations are largely based on expert consensus, observational or epidemiologic studies. Few studies directly address questions of whether changing practice decreases risk. Given the pressing need to address opioid-related adverse outcomes, guideline developers generally agree on forging recommendations based on relatively weak or indirect evidence now rather than waiting for more rigorous studies.

CONSIDERATIONS FOR REVIEWING SOUTH CAROLINA PRESCRIPTION

A SCRIPTS Narx Report (also called a DHEC or PMP report) is one tool to help confirm a patient's controlled

WHAT IF:

APPARENTLY GOOD RESULTS (1 PHARMACY, 1 OPIOID PRESCRIBER)[1]

- Does it match clinical evaluations (e.g., urine drug test) and patient interviews?
- Consider non-adherence behaviors not captured in results (e.g., binging, running out early).

WHAT IF:

TOTAL MORPHINE MILLIGRAM EQUIVALENTS PER DAY (MME/day)[2] SUGGESTS CONCERN FOR ADVERSE EVENTS OR OVERDOSE[3,4]

- Before increasing dose to ≥ 50 MME/day carefully assess if the diminishing benefit in pain or function outweighs the increasing overdose risks.
- More recent guidelines recommend additional precautions when prescribing ≥ 50 MME/day including more frequent follow-up, offering naloxone, and providing overdose prevention education to patients and caregivers.
- Guidelines do not recommend abrupt tapering or discontinuation of opioids. For patients already on higher opioid daily doses, carefully weigh risks and benefits of tapering or continuing opioid dose.

No opioid daily dose has zero risk.

WHAT IF:

NARCOTIC NARX SCORE[5,6] OR OVERDOSE RISK SCORE (ORS)[7] SUGGESTS CONCERN FOR ADVERSE EVENTS OR OVERDOSE[4]

- Narcotic Narx Scores are indicators of opioid use and risk for adverse outcomes based on increased use.
- Suggested recommendations for ORS > 450 are intended to be comparable to those for patients prescribed at or above 50 MME/day.
- Do scores match clinical evaluations (e.g., urine drug test) and patient interviews?
- Concerning scores should prompt a discussion with the patient and not a quick decision regarding medication continuation.

Data suggest co-prescribing naloxone AND providing overdose education to patients, family, and friends encourages safer opioid use and reduces overdose rate.

WHAT IF:

COMBINATION OF OPIOID AND OTHER CONTROLLED SUBSTANCE(S), ESPECIALLY BENZODIAZEPINES[8,9,10]

- Pain guidelines concur benzodiazepines and opioids are high risk combinations, especially in the elderly; many recommend against combination unless clearly indicated.
- Is the combination clearly indicated? If clearly indicated, is the patient prescribed the lowest effective dose(s)?
- What is the patient's level of functioning?

For more information on tapering opioids and/or benzodiazepines visit:
https://bit.ly/opioids_benzos

WHAT IF:

OPIOID-ACETAMINOPHEN COMBINATION PRODUCT

- Consider possibility that patient is taking other prescription medications or over-the-counter products containing acetaminophen.
- Counsel patient on risk of exceeding 4000 mg total daily acetaminophen dose or combining with alcohol.[10]

MONITORING PROGRAM (SCRIPTS) NARX REPORTS

substance (C-II – C-IV) drug history, adherence, or potential drug abuse/misuse/diversion

WHAT IF:

POTENTIAL ABERRANT BEHAVIOR (2 OR MORE PHARMACIES, 2 OR MORE OPIOID PRESCRIBERS)[3]

- Does it match clinical evaluations (e.g., urine drug test) and patient interviews?
- Consider differential diagnosis for possible inappropriate opioid use:

☐ **ADDICTION** - often characterized by behaviors that may include loss of control over drug use, craving, compulsive use, and continued use despite harm to health or relationships (See table at right)

Physical dependence and tolerance are normal physiologic adaptations to extended opioid therapy and are NOT the same as addiction.

☐ **PHYSICAL DEPENDENCE** - biologic adaptation to drug that results in abstinence syndrome (signs and symptoms of withdrawal) upon cessation, rapid dose reduction and/or administration of antagonist

☐ **TOLERANCE** - a physiologic state of reduced effect over time from regular drug exposure in which increased dosage is needed to produce specific effect (*increase in dose and no increase in effect may mean opioid is ineffective*)

☐ **HYPERALGESIA** - increase in pain sensitivity that can be seen with rapid opioid dose escalation or high opioid dose (*consider if increase in pain with increase in dose*)

☐ **PSEUDO-ADDICTION** - aberrant drug-related behaviors driven by uncontrolled pain (*relief seeking vs drug seeking*) that are reduced by improved pain control

☐ **OTHER PSYCHIATRIC ILLNESSES** - such as anxiety, depression, PTSD, "chemical coping" (knowingly or unknowingly taking medications to decrease or numb negative emotions)

☐ **DIVERSION** - moving medications from legal/medically indicated users to illegal/unauthorized users

CONCERNING BEHAVIORS FOR ADDICTION
○ Requests for increases in opioid dose
○ Requests for specific opioid by name, "brand name only" or allergic to all but the desired opioid
○ Overwhelming focus on opioids during visits instead of underlying disease process
○ Multiple office contacts regarding opioids
○ Unwilling to follow through with recommended therapy/referrals (e.g., physical therapy)
○ Running out early due to unsanctioned dose escalation
○ Resistance to change therapy despite harm or negative consequences (e.g., over-sedation); unwilling to consider non-opioid therapy
○ Concurrent alcohol or substance abuse
○ Deterioration in function at home and work
○ Opposition to monitoring (e.g., pill counts, UDT)
○ Three or more requests for early refills
○ Multiple "lost," "spilled," or "stolen" opioid prescriptions
○ Multiple sources for opioids
○ Illegal activities – forging prescriptions, selling opioid prescriptions
○ Overdose

Adapted with permission: Boston University SCOPE of Pain Program www.scopeofpain.com

When patient behavior suggests concern for addiction, assess for Opioid Use Disorder (OUD). Patients with OUD often have poor outcomes when "*kicked out*" of care and typically respond better when care is "*kicked up*". OUD is a manageable chronic disease, just like hypertension or diabetes; **consider offering medications for opioid use disorder (MOUD)** or referral for treatment.

If you are interested in learning more about MOUD at your practice, please visit https://bit.ly/tipSC_MOUD and/or attend Project ECHO Opioid Use Disorder Telementoring and Educational Sessions (https://bit.ly/MUSC_ECHO)

[1] Not all dispensed opioids require reporting to SCRIPTS, such as methadone dispensed from Opioid Treatment Programs (i.e., 'methadone clinics') or < 48-hour supply from emergency department.
[2] Morphine Milligram Equivalents (MME) is a mathematical conversion that standardizes risk evaluation of the different opioids.
[3] Increased risk of opioid overdose-related death has been associated with 4+ opioid prescriptions, 4+ pharmacies, or total MME/day ≥ 100.
[4] Opioid overdose risk increases in a dose-response manner; dosages ≥ 50 total MME/day increase risks for overdose by at least 2 times the risk of dosages < 20 total MME/day.
[5] The first two digits of the three-digit Narx Score is a 00-99 relative risk score and the last digit corresponds to the total number of potentially active opioid prescriptions.
[6] All Narx Scores (i.e., Narcotic, Sedative, or Stimulant) include a 2-digit relative risk score and a count of potentially active prescriptions (i.e., opioids, sedatives or stimulants).
[7] The Overdose Risk Score (ORS) indicates the relative risk of unintentional overdose death, the risk doubling with every 100 point increase (e.g., a score of 300 is two times the risk of 200, 500 is eight times the risk of 200).
[8] Benzodiazepines and opioid medication labelings carry black box warnings highlighting the risks associated with concomitant use.
[9] Lorazepam milligram equivalent (LME) values in SCRIPTS offer one way to compare sedative hypnotic medications for dose-related risk considerations.
[10] Consider 3000 mg total daily dose, especially if elevated liver function tests, known liver impairment, or older age; use 2000 mg total daily dose in patients with alcohol use disorder or taking warfarin.

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The information contained in this summary is intended to assist primary care providers in the management of chronic non-cancer pain in adults in the primary care setting. This information is advisory only and is not intended to replace sound clinical judgement, nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac, liver and renal impairment; debility; addiction; and pregnancy/breast-feeding).