A guide for primary care providers

Opioid Stewardship & Chronic Pain

SIH

Letter to Readers

As part of our commitment to patient care and quality and due to Southern Illinois having higher rates of patient opioid prescriptions, SIH has been examining and improving practices and policies related to pain assessment, pain management and safe opioid prescribing and use. This Guide for Primary Care Providers on Opioid Stewardship and Chronic Pain, will provide information on CDC prescribing guidelines, pain management options and assessment, and information about substance misuse treatment and medication. We want to thank all of our physicians and advance practice providers for their care for patients throughout the Southern Illinois region. The SIH Pain Management Team will continue to provide support and education to our staff in order to provide consistent, quality care to our patients.

Marci Moore-Connelley, MD, MBA

Senior Vice President & Chief Medical Officer

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46 people die every day from overdoses involving prescription opioids. In 2017, prescription opioids contributed to the U.S. epidemic as they were involved in more than 35% of all opioid overdose deaths.[1]

Source: https://www.cdc.gov/drugoverdose/data/prescribing.html

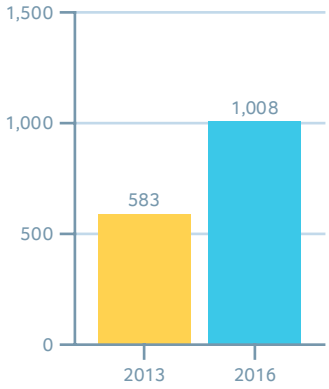
1,946
Opioid overdose deaths in 2016

1.5x
Homicides in 2016

2x
Fatal car crashes in 2016

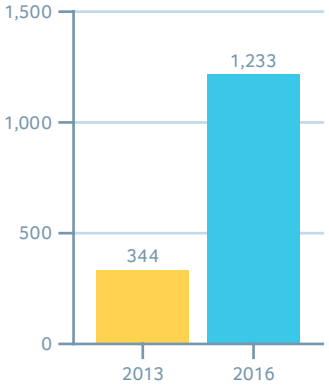
Drug overdose deaths 2016

Heroin overdose deaths



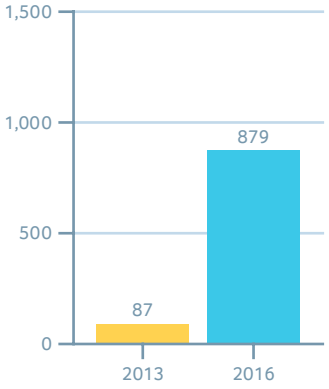
Doubled

Prescription opioid overdose deaths



Quadrupled

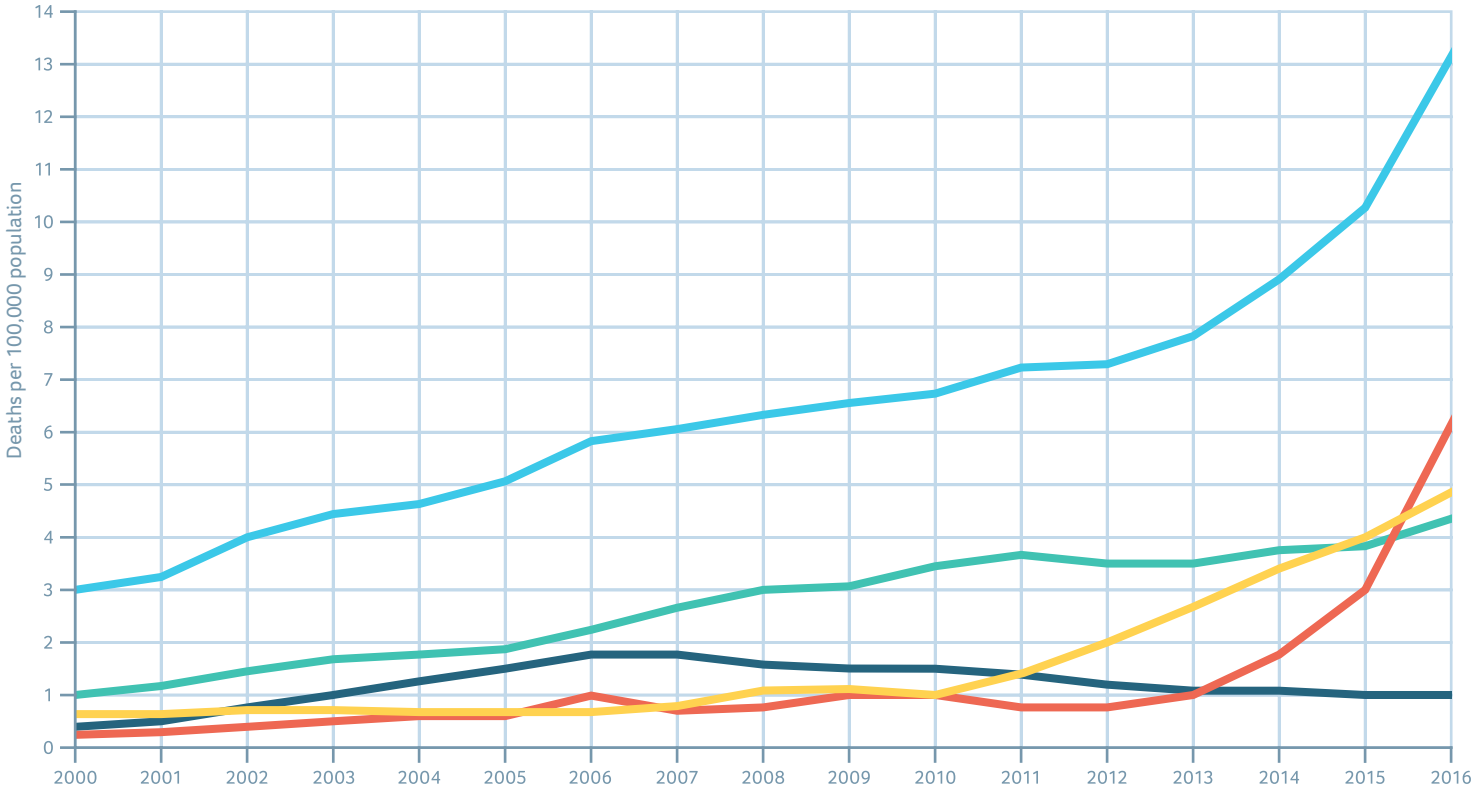
Synthetic opioids overdose deaths



Increased Ten Fold

Overdose is the leading cause of injury-related death in the US

Overdose deaths involving opioids, by type of opioid, United States, 2000–2016[2]



- Any Opioid
- **Natural & Semi-Synthetic Opioids** *(e.g., oxycodone, hydrocodone)*
- **Heroin**
- **Methadone**
- **Other Synthetic Opioids** *(e.g., fentanyl, tramadol)*

Opioids—mainly synthetic opioids (other than methadone)—are currently the main driver of drug overdose deaths. Opioids were involved in 47,600 overdose deaths in 2017 (67.8% of all drug overdose deaths).[3]

Source: https://www.cdc.gov/drugoverdose/data/statedeaths.html

In 2017, there were 70,237 drug overdose deaths in the United States.[4]

Source: https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf

Among persons aged 15 and over, adults aged 25–34, 35–44, and 45–54 had the highest rates of drug overdose deaths in 2016.[2]

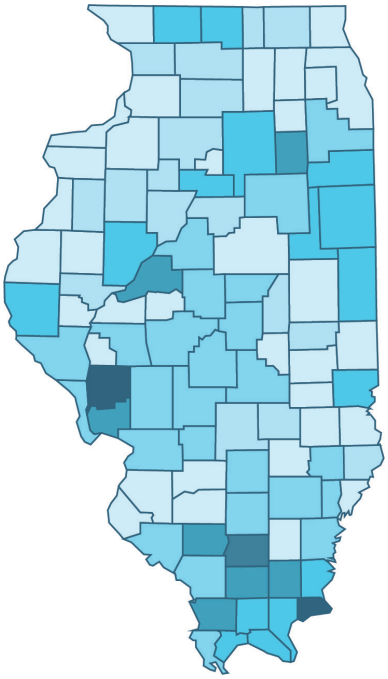
Source: https://www.cdc.gov/nchs/data/databriefs/db294.pdf

The rate of drug overdose deaths involving synthetic opioids other than methadone doubled in a single year.[2]

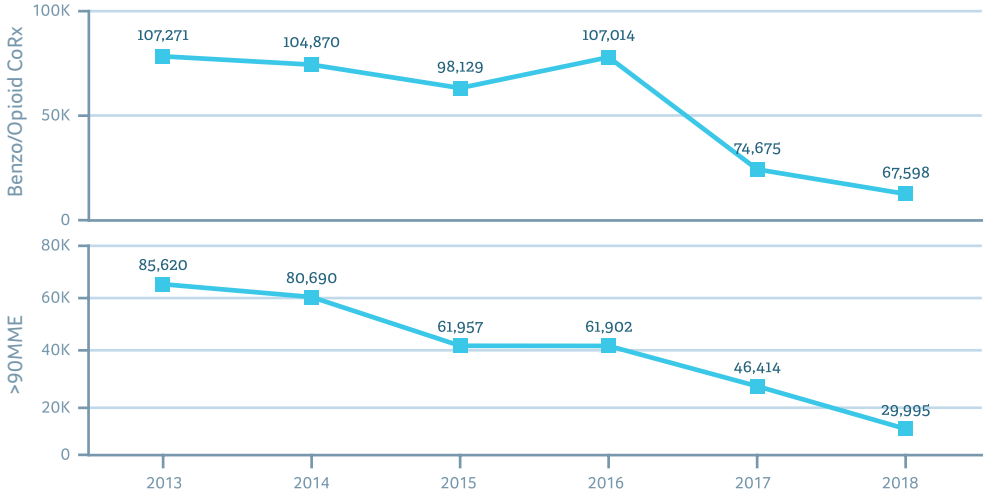
Source: https://www.cdc.gov/nchs/data/databriefs/db294.pdf

Opioid overdose deaths in Illinois

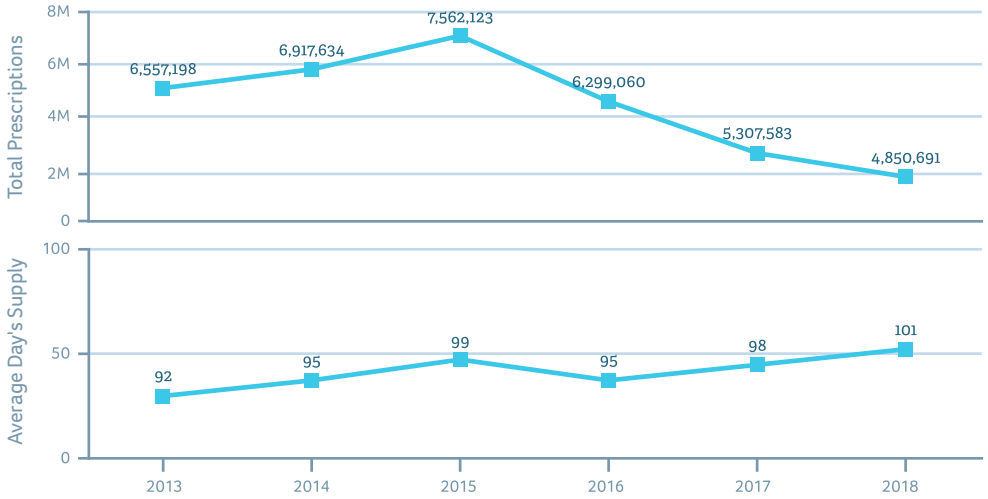
>90 MME Rate 2018 [5]



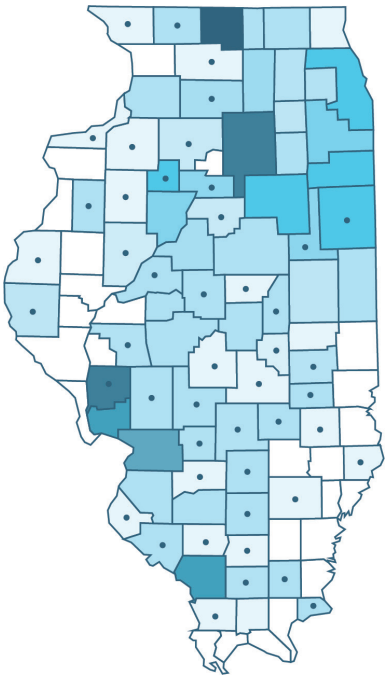
High risk patient populations



Total Rxs & Average Days' Supply



Fatal Overdose Rate 2018 [5]



	Heroin	Other Opioids	Total
Fatal	1,008	1,806	2,063
Non-Fatal	9,389	4,327	13,616

Rate

0.54 — 23.45

Accidental opioid overdose is preventable

Prior opioid overdose is a major risk for subsequent overdose and overdose death. A patient who has previously overdosed is **6 times more likely to overdose** in the subsequent year.[6]

Other factors that increase risk of overdose:

Reduced tolerance: period of abstinence, change in dose, release from incarceration	*Genetic predisposition*	*Concomitant use of substances: benzodiazepines, alcohol, cocaine*

The majority of opioid overdose deaths involve at least one other drug, including benzodiazepines, cocaine or alcohol.[7]

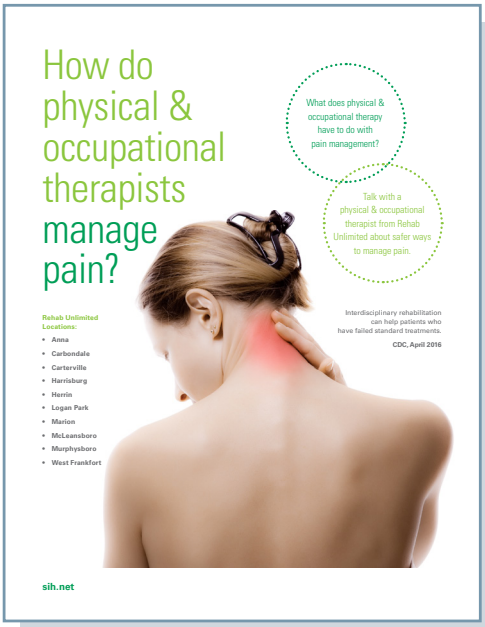
Managing chronic non-cancer pain

If opioid medication is part of the treatment plan, take the following steps:

- Assessments of risk, adherence, function and pain: at least annually
- Informed consent or pain agreement: at least annually
- Prescription drug monitoring program: check Illinois Prescription Monitoring Program every 4 months
- Prescribe Naloxone: every two years

If managing opioid use disorder, options include:

- Prescribe buprenorphine
- Arrange for methadone maintenance or extended-release naltrexone
- Arrange for residential or outpatient treatment



Reference #8

Pain and function assessments

Assessments should focus on both pain and function.

- Assessments are essential when initiating opioid treatment or seeing a new patient already on long-term opioid therapy.
- Reassessments should take place at regular intervals to ensure benefit and evaluate adverse events.

CDC Recommends

Assessments should take place within three months of starting treatment and at least annually thereafter.

SIH Policies

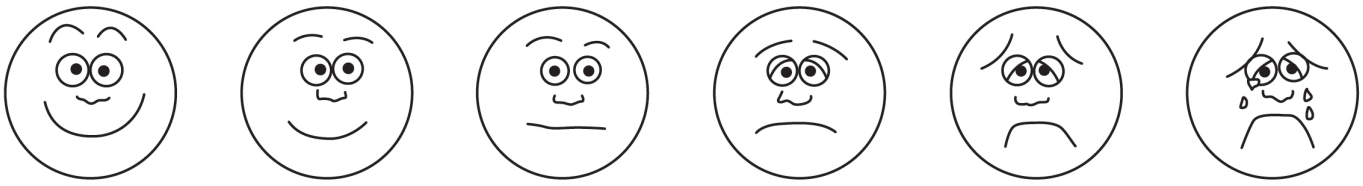
- For more information on pain and function assessments see the following SIH policy:

  Pain Assessment & Management SY-NG-021

Tools

- There are several tools for assessing pain and function such as the "Wong-Baker FACES Pain Rating Scale", which is one of the rating scales used at SIH.

Wong-Baker FACES® Pain Rating Scale



0	2	4	6	8	10
No Pain	A Little Pain	A Little More Pain	Even More Pain	A Whole Lot Of Pain	Worst Pain

Risk factor assessment

Once you have determined that opioids are indicated for a patient, assessing for risk factors may help guide therapeutic decisions.

Assessing for risk of an opioid use disorder can be done with simple questions like:

"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" [9]

In a primary care setting (with an answer of one or more considered positive) this question was 100% sensitive and 73.5% specific in detecting a substance use disorder compared with a standardized diagnostic screening.

When assessing for safety with opioid therapy, consider:

- Concomitant medications (particularly benzodiazepines)
- Comorbidities that can affect respiration (e.g. sleep apnea, tobacco or alcohol use disorder)
- History of prior overdose or similar adverse reaction to opioids
- Total daily dose of opioids

The presence of risk factors does not necessarily contraindicate opioid therapy, but can be used to emphasize alternatives, limit dose and intensify monitoring.

Urine drug screening

Urine drug screening can be used to check for substances that are expected and not expected to be present. This can help guide an informed discussion with patients about their medications.

- **Urine drug screening should NOT be used as a punitive tool,** rather it should be used like hemoglobin A1C, as a guide to ensure optimal care.
- Urine drug testing should be done more frequently for patients at higher risk.

CDC Recommends

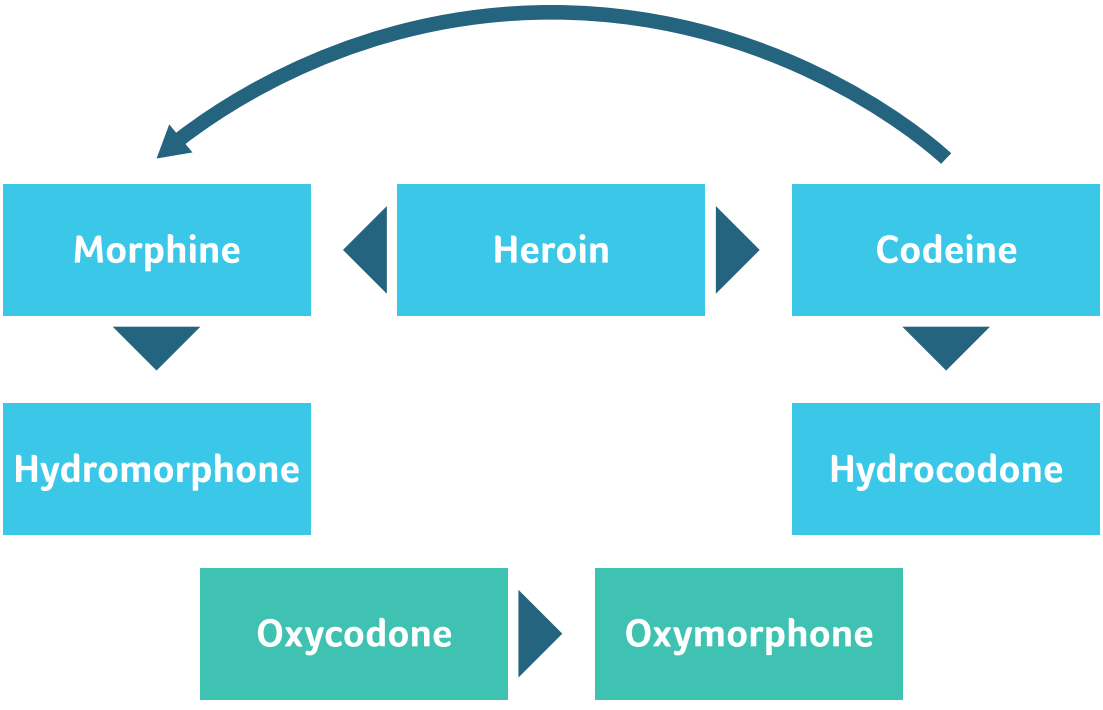
Conduct urine drug screening at first opioid prescription and at least annually thereafter.

Contact your lab for assistance interpreting urine drug screening results

Tests and interpretations can vary by lab. Reach out to your local lab when you need help interpreting results.

- **Not all assays test for all substances.** Opioids like methadone, fentanyl and buprenorphine may not appear on all tests.
- **Some opioids may be metabolites of opioids a patient is prescribed.** For example, the presence of hydromorphone in the urine of a patient prescribed morphine may be due to metabolism rather than use of non-prescribed opioids.

Opioid metabolic pathways



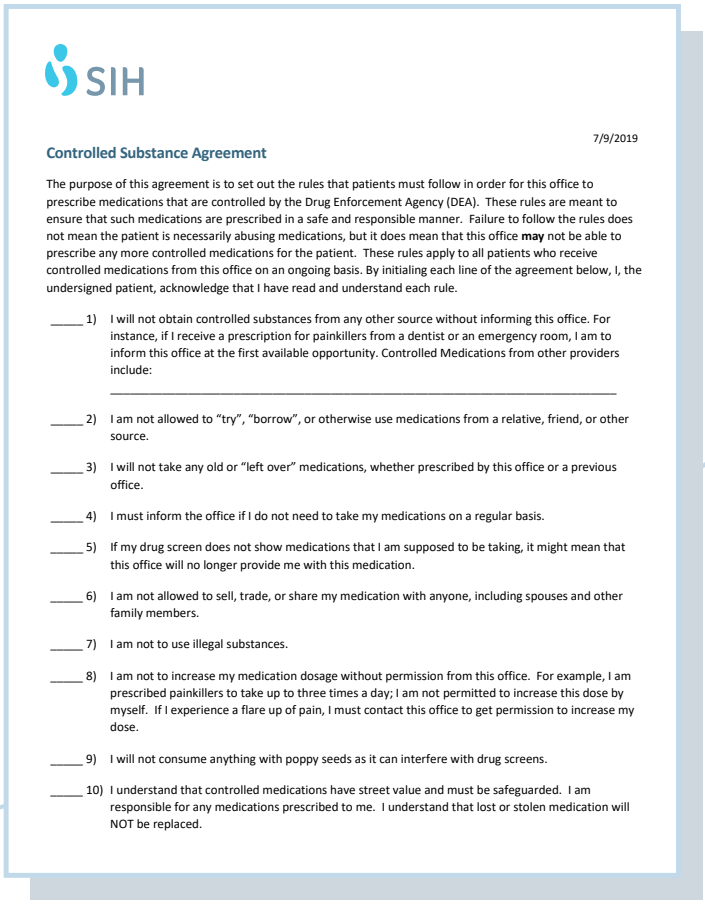
Informed consent and treatment agreements

- Informed Consent is a joint discussion between provider and patient, documented in the chart, addressing risks associated with opioids and clarifying expectations.
- Treatment agreements are written documents, similar to and possibly replacing informed consent, that address risks of opioid therapies, as well as expectations of both the patient and provider. Pain agreements are generally signed by the patient and renewed annually.

CDC Recommends

Review informed consent or treatment agreements at least annually.

At a minimum, providers should offer written information to patients about the benefits and risks of opioid therapy and document patients' understanding and agreement when initiating long-term opioid therapy and ***at least annually*** *thereafter.*



SIH

7/9/2019

Controlled Substance Agreement

The purpose of this agreement is to set out the rules that patients must follow in order for this office to prescribe medications that are controlled by the Drug Enforcement Agency (DEA). These rules are meant to ensure that such medications are prescribed in a safe and responsible manner. Failure to follow the rules does not mean the patient is necessarily abusing medications, but it does mean that this office **may** not be able to prescribe any more controlled medications for the patient. These rules apply to all patients who receive controlled medications from this office on an ongoing basis. By initialing each line of the agreement below, I, the undersigned patient, acknowledge that I have read and understand each rule.

_____ 1) I will not obtain controlled substances from any other source without informing this office. For instance, if I receive a prescription for painkillers from a dentist or an emergency room, I am to inform this office at the first available opportunity. Controlled Medications from other providers include:
_____

_____ 2) I am not allowed to "try", "borrow", or otherwise use medications from a relative, friend, or other source.

_____ 3) I will not take any old or "left over" medications, whether prescribed by this office or a previous office.

_____ 4) I must inform the office if I do not need to take my medications on a regular basis.

_____ 5) If my drug screen does not show medications that I am supposed to be taking, it might mean that this office will no longer provide me with this medication.

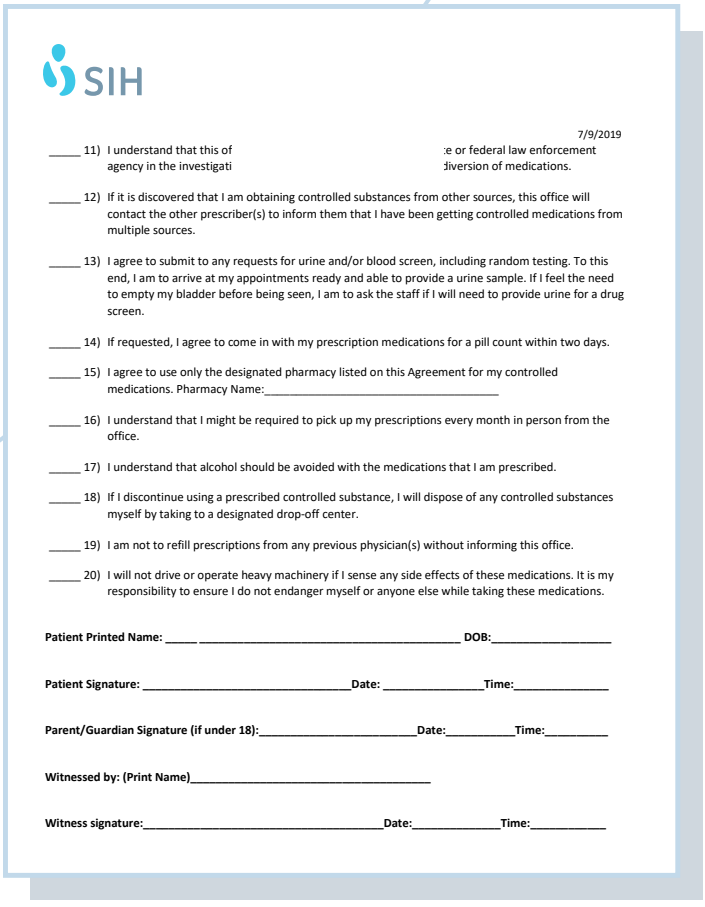
_____ 6) I am not allowed to sell, trade, or share my medication with anyone, including spouses and other family members.

_____ 7) I am not to use illegal substances.

_____ 8) I am not to increase my medication dosage without permission from this office. For example, I am prescribed painkillers to take up to three times a day; I am not permitted to increase this dose by myself. If I experience a flare up of pain, I must contact this office to get permission to increase my dose.

_____ 9) I will not consume anything with poppy seeds as it can interfere with drug screens.

_____ 10) I understand that controlled medications have street value and must be safeguarded. I am responsible for any medications prescribed to me. I understand that lost or stolen medication will NOT be replaced.



SIH

7/9/2019

_____ 11) I understand that this of :e or federal law enforcement agency in the investigati :iversion of medications.

_____ 12) If it is discovered that I am obtaining controlled substances from other sources, this office will contact the other prescriber(s) to inform them that I have been getting controlled medications from multiple sources.

_____ 13) I agree to submit to any requests for urine and/or blood screen, including random testing. To this end, I am to arrive at my appointments ready and able to provide a urine sample. If I feel the need to empty my bladder before being seen, I am to ask the staff if I will need to provide urine for a drug screen.

_____ 14) If requested, I agree to come in with my prescription medications for a pill count within two days.

_____ 15) I agree to use only the designated pharmacy listed on this Agreement for my controlled medications. Pharmacy Name:_____

_____ 16) I understand that I might be required to pick up my prescriptions every month in person from the office.

_____ 17) I understand that alcohol should be avoided with the medications that I am prescribed.

_____ 18) If I discontinue using a prescribed controlled substance, I will dispose of any controlled substances myself by taking to a designated drop-off center.

_____ 19) I am not to refill prescriptions from any previous physician(s) without informing this office.

_____ 20) I will not drive or operate heavy machinery if I sense any side effects of these medications. It is my responsibility to ensure I do not endanger myself or anyone else while taking these medications.

Patient Printed Name: _____ _____ DOB:_____

Patient Signature: _____Date: _____Time:_____

Parent/Guardian Signature (if under 18):_____Date:_____Time:_____

Witnessed by: (Print Name)_____

Witness signature:_____Date:_____Time:_____

There are pain agreement templates available online. See SIH Resource section for more info.

What to include in a treatment agreement

Essential

- Reason for treatment
- Potential benefits and risks
- Assessments
- Expectations for future visits
- Discontinuation plan

Optional

- Additional elements of treatment plan (medication, other non-opioid treatments, physical therapy, etc.)
- Therapeutic goals, including physical ability, social function, dosing, duration
- Requirements for external consultation

Unused medications?

Unused medications can be disposed of at the following SIH locations

SIH Memorial Hospital of Carbondale
405 W. Jackson St. | Carbondale, IL 62902
Mon – Fri: 7:30 am – 6:00 pm | Sat – Sun: 7:30 am – 6:00 pm

SIH Herrin Hospital
201 S. 14th St. | Herrin, IL 62948
Mon – Fri: 7:30 am – 6:00 pm | Sat – Sun: 7:30 am – 6:00 pm

SIH St. Joseph Memorial Hospital
2 S. Hospital Dr. | Murphysboro, IL 62966
Mon – Fri: 6:00 am – 4:30 pm | Sat – Sun: 7:00 am – 2:30 pm

SIH Cancer Institute
1400 Pin Oak Dr. | Carterville, IL 62918
Mon – Fri: 7:30 am – 3:30 pm | Sat – Sun: CLOSED

Additional considerations

Patient engagement

- Remind patients to keep opioids in a locked and safe place.
- Encourage safe disposal of drugs.
- SIH has drug disposal units for the public at all three SIH hospitals and the SIH Cancer Institute. Take back events are also held periodically in the community.

When prescribing opioids

Starting opioid therapy

CDC Recommends

Consider using episodic short-acting opioids and keeping at lowest effective dose.

Exercise caution

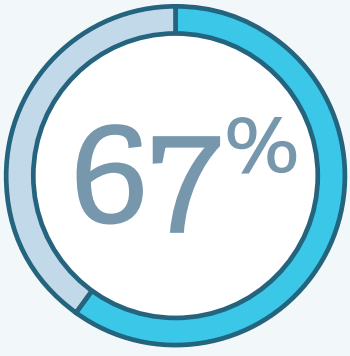
- Doses ≥ 50 MME
- Concurrent use of benzodiazepine, alcohol or methadone for pain

Avoid if possible

- Doses ≥ 90 MME

Inheriting patients already on opioid therapy can be complex

- Discuss with former provider
- Complete baseline assessments
- Establish expectations
- Engage in opioid use disorder treatment if appropriate



67% of those prescribed opioids for 90 days are still using opioids at 2 years.[10]

Tapering or discontinuing opioids

When to taper

» When risks outweigh benefits

Consider tapering when opioid dose ≥90 MME or patient also takes benzodiazepines.

How to taper

» 1 medication at a time

» Tapers usually involve a monthly reduction of 10% of original dose

» Tapers may be as rapid as 50% in situations such as a low original dose or life-threatening adverse events

Consider a partial taper or transition to buprenorphine for some patients, particularly those on years of opioid therapy.

"I am more alert since I stopped taking [opioids] and I need less sleep, which is a blessing. So I'm able to do more things with my life."

- Patient formerly prescribed opioids for pain

CDC Recommends

Patient engagement

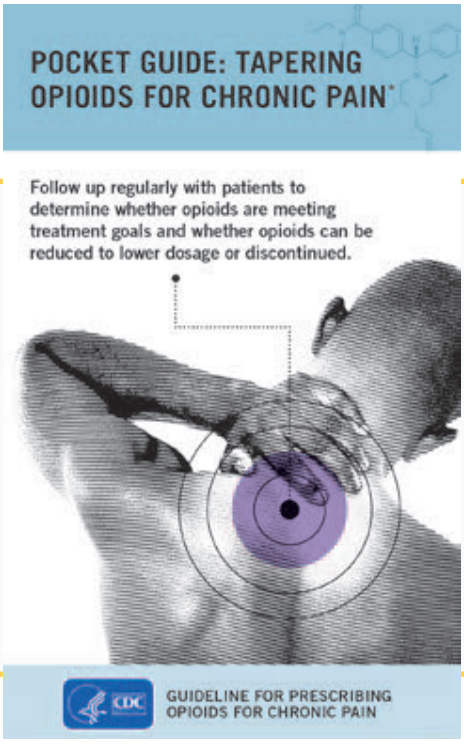
» Individualize the plan and be prepared to adjust

» Work with patient to set realistic goals

» Remind patient that reducing opioid use may reduce sensitivity to pain

» Encourage patient to engage support networks

» Use motivational interviewing techniques



Go to this link for a CDC patient toolkit on tapering:

tinyurl.com/hfr7drd

Illinois Prescription Monitoring Program (IL PMP)

Illinois' Prescription Monitoring Program (IL PMP) is an online system used by prescribers to review prescriptions of controlled substances.

- The PMP is a database which collects information on controlled substance prescriptions dispensed by retail pharmacies in Illinois.
- Public Act 100-0564 required prescribers with a controlled substance license to register on the PMP.
- Prescribers or designee shall document in the patient electronic health records (EHR) an attempt to access the PMP to assess patient access to controlled substances upon an initial prescription (each prescription is considered an initial prescription).

What information is provided by the PMP?

- Schedules II – V controlled substances prescriptions are viewable for 12 months and archived for two years.

Who can access the ilpmp.org site?

- Physicians
- Pharmacists
- Dentists
- Veterinarians
- Physician Assistants and Advanced Practice Nurses
- Other prescribers and dispensers

High quality prescription drug monitoring programs with mandated use may be associated with reduced opioid prescribing[11] and modest reductions in opioid analgesic deaths.[12]

All retail pharmacies that dispense schedule drugs are required to report their prescription to the IL PMP on a daily basis. The prescriptions are then collected and updated on the IL PMP website each business day.

How to register for the Illinois Prescription Monitoring Program

How do I register for the PMP?

1. Go to www.ilpmp.org.
2. Watch “How to” video found under the Help & FAQ tab.
3. Go to the home page and click onto the Prescriber Link on the left side.
4. Fill out registration form and submit.
5. PMP will contact you with your user name (log in ID).
6. Insert user name, password, and security code .
   (Note: user name is not case sensitive, the remainder are)

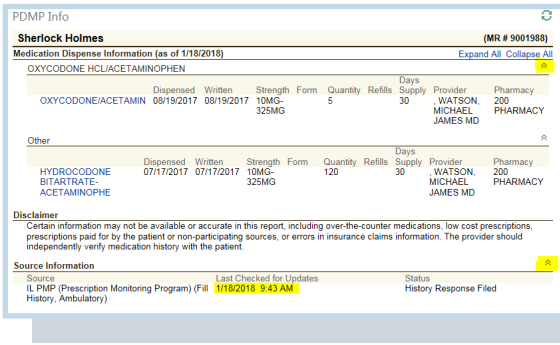
There is a contact phone number listed if difficulties arise.

IL PMP Legislation

SB772 amends the Illinois Controlled Substances Act and has been effective since January 1, 2018, imposing several obligations on prescribers.

- First, all prescribers who hold an Illinois Controlled Substances license must register with the PMP. Click here to register.
- Next, before giving a patient a new prescription for a Schedule II narcotic prescribers or their designee must attempt to access the patient's information in the PMP and assess the patient's controlled substance history. Prescriptions for oncology treatment or palliative care, or for a 7-day or less supply provided by a hospital emergency department for an acute, traumatic medical condition, are exempt from the requirement. Prescribers must document the attempt to access the PMP in the patient's medical record.

Medications from IL PMP pull into the patient's chart in Epic. Workflows have been developed for ambulatory, inpatient and ASAP that will allow the providers to review IL PMP within Epic and document the review in their note in an efficient manner.


PDMP Info

Sherlock Holmes (MR # 9001988)

Medication Dispense Information (as of 1/18/2018) Expand All Collapse All

OXYCODONE HCL/ACETAMINOPHEN

	Dispensed	Written	Strength	Form	Quantity	Refills	Days Supply	Provider	Pharmacy
OXYCODONE/ACETAMIN	08/19/2017	08/19/2017	10MG-325MG		5		30	, WATSON, MICHAEL JAMES MD	200 PHARMACY

Other

	Dispensed	Written	Strength	Form	Quantity	Refills	Days Supply	Provider	Pharmacy
HYDROCODONE BITARTRATE-ACETAMINOPHE	07/17/2017	07/17/2017	10MG-325MG		120		30	, WATSON, MICHAEL JAMES MD	200 PHARMACY

Disclaimer

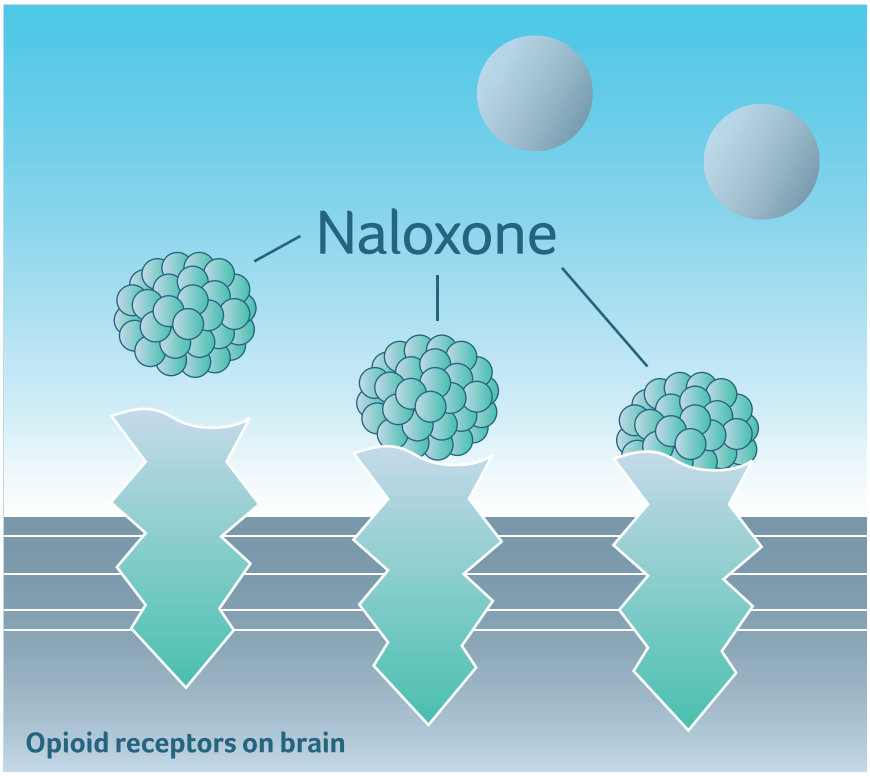
Certain information may not be available or accurate in this report, including over-the-counter medications, low cost prescriptions, prescriptions paid for by the patient or non-participating sources, or errors in insurance claims information. The provider should independently verify medication history with the patient.

Source Information

Source	Last Checked for Updates	Status
IL PMP (Prescription Monitoring Program) (Fill History, Ambulatory)	1/18/2018 9:43 AM	History Response Filed

IL PMP alerts prescribers to patients with multiple prescribers, high-dose opioid prescriptions, concomitant opioids and benzodiazapines and daily opioids over 90 days.

Naloxone



Naloxone mechanism of action

- Highly specific, high-affinity opioid antagonist used to reverse the effects of opioids
- Lasts 30-90 minutes
- Can be administered by laypeople
- Virtually no side effects or effects in the absence of opioids

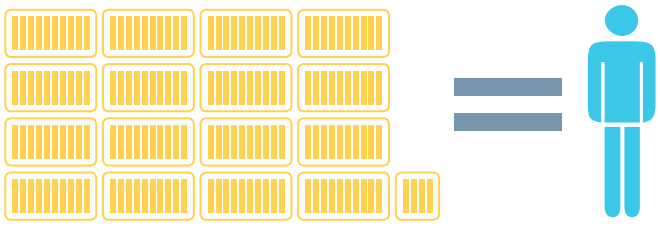
Providing Naloxone to people who use drugs is cost-effective[13]

Cost

$421 per quality-adjusted life-year gained

Benefit

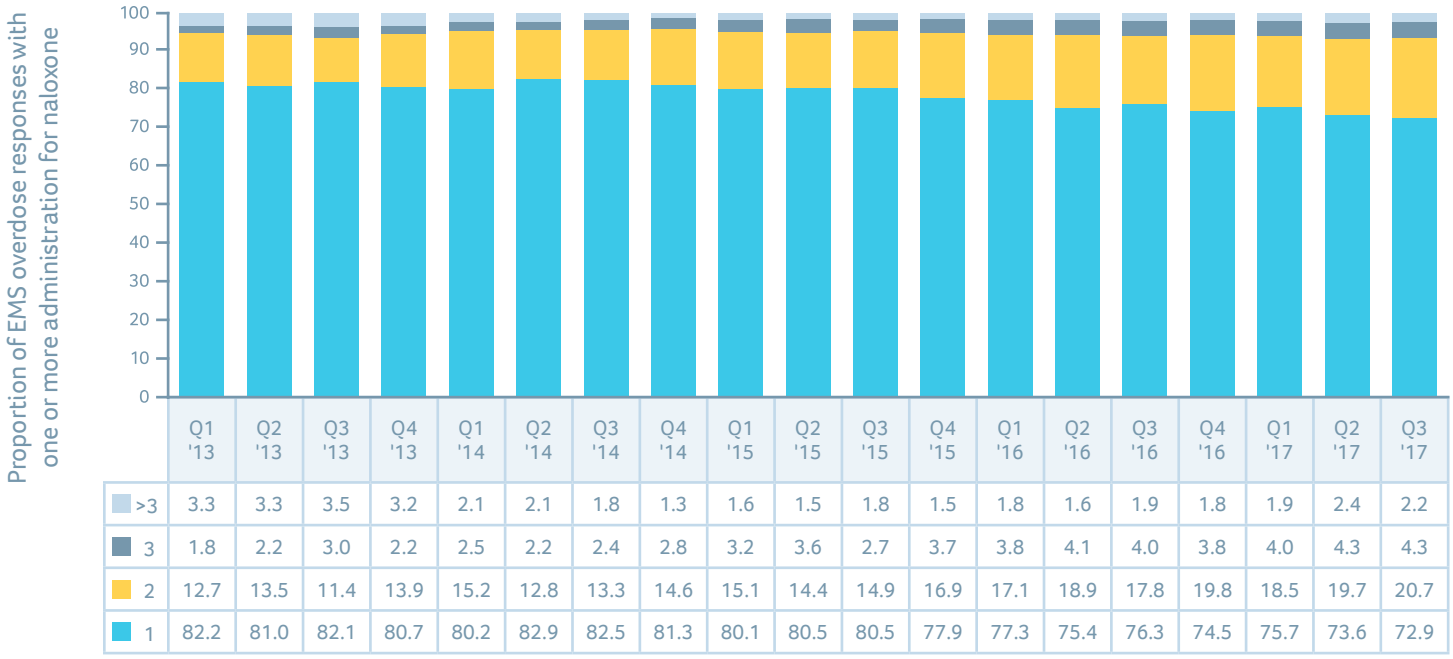
164 naloxone scripts = 1 prevented death



Emerging data suggests that providing naloxone may encourage patients to be safer with their opioid use. If this is the case, the intervention would be cost-saving and 36 prescriptions would prevent one death.

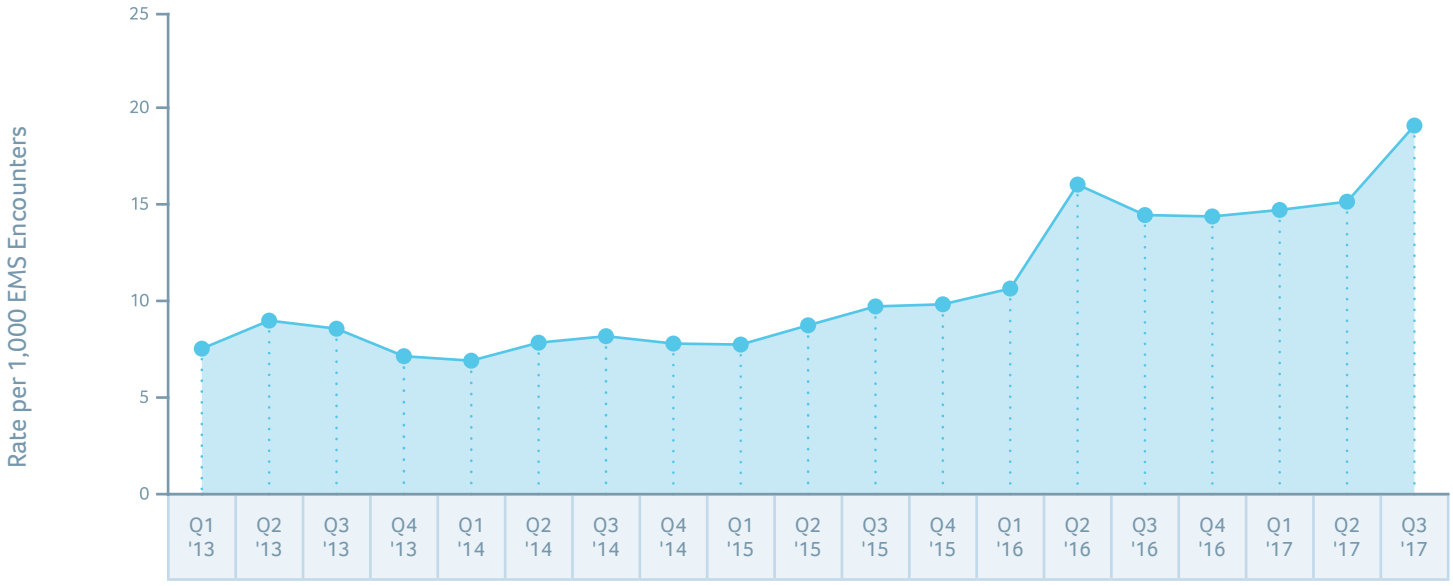
Naloxone is effective

Naloxone administrations per EMS overdose event [14]



	Q1 '13	Q2 '13	Q3 '13	Q4 '13	Q1 '14	Q2 '14	Q3 '14	Q4 '14	Q1 '15	Q2 '15	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Q3 '16	Q4 '16	Q1 '17	Q2 '17	Q3 '17
>3	3.3	3.3	3.5	3.2	2.1	2.1	1.8	1.3	1.6	1.5	1.8	1.5	1.8	1.6	1.9	1.8	1.9	2.4	2.2
3	1.8	2.2	3.0	2.2	2.5	2.2	2.4	2.8	3.2	3.6	2.7	3.7	3.8	4.1	4.0	3.8	4.0	4.3	4.3
2	12.7	13.5	11.4	13.9	15.2	12.8	13.3	14.6	15.1	14.4	14.9	16.9	17.1	18.9	17.8	19.8	18.5	19.7	20.7
1	82.2	81.0	82.1	80.7	80.2	82.9	82.5	81.3	80.1	80.5	80.5	77.9	77.3	75.4	76.3	74.5	75.7	73.6	72.9

EMS patient encounters involving Naloxone per 1,000 EMS encounters [14]



Indications for naloxone prescribing

"By being able to offer something concrete [naloxone] to protect patients from the danger of overdose, I am given an opening to discuss the potential harms of opioids in a non-judgmental way."

-Primary care provider

Consider naloxone for patients:

- With past illicit opioid use
- At risk of witnessing an opioid overdose

CDC Recommends

On prescribed opioids with:

- Opioid use ≥50 MMEs/day
- Benzodiazepine use
- History of substance use disorder
- History of opioid overdose
- Other factors that increase overdose risk, including comorbidities or concomitant medications

"I have never really thought about [overdose] before...[naloxone] was more so an eye opener for me to just look at my medications and actually start reading [about] the side effects, you know, and how long should I take them...I look at different options, especially at my age."

-Patient on opioids for pain

State law encourages naloxone prescribing

Naloxone is NOT a controlled substance. Any licensed healthcare prescriber can prescribe naloxone. Illinois law provides additional protections to encourage naloxone prescribing and distribution.

Provider and patient protections

- Providers are encouraged to prescribe naloxone to patients receiving a long-term opioid prescription.
- Naloxone prescriptions also can be written directly to third party individuals (caregivers, family members, friends, etc.) who are in a position to witness and assist a person at risk of an opioid overdose.
- A licensed healthcare prescriber can issue a standing order for the dispensing of naloxone by healthcare or community workers to individuals at risk of experiencing or witnessing an overdose.
- Laypeople can possess and administer naloxone to others during an overdose situation.

Good Samaritan Protections

- The Emergency Medical Services Access Law (PA 097-0678, 2012, i.e., Good Samaritan Law), or Illinois' "Good Samaritan Law" allows individuals to seek emergency medical help for an overdose without risking criminal liability for possession.

Pharmacist provision of naloxone

- Pharmacists are allowed to directly prescribe and dispense naloxone to patients at risk of experiencing or witnessing an opioid overdose.

Illinois Laws

- The Illinois Drug Overdose Prevention Program Law (PA 096-0361, 2010) empowers non-medical professionals, including family, friends, and other community members, to administer naloxone to prevent a fatal opioid overdose without risking any civil or criminal liability.
- The Emergency Medical Services Access Law (PA 097-0678, 2012, i.e., Good Samaritan Law), or Illinois' "Good Samaritan Law" allows individuals to seek emergency medical help for an overdose without risking criminal liability for possession.
- The Heroin Crisis Act (PA 099-0480, 2015), also called "Lali's Law," among other things increases access to naloxone, strengthens the Illinois Prescription Monitoring Program (ILPMP), and provides greater access to medication-assisted treatment for opioid use disorder.
- Public Act 100-0564 (2017) mandates that prescribers with controlled substances licenses register with the ILPMP and that they document an attempt to check the ILPMP when providing an initial prescription for opioids (with certain exceptions).

Illinois statewide Naloxone standing order

The statewide Illinois Naloxone Standing Order authorizes trained, licensed pharmacists and overdose education and naloxone distribution (OEND) programs to dispense naloxone to anyone who requests it for the use of reversing a potential opioid overdose, even if they don't have an individual prescription for the medication. The order was issued by the Chief Medical Officer of the Illinois Department of Public Health on September 7, 2017 and will be renewed annually.

Who may obtain and use the Illinois Naloxone Standing Order?

Eligible entities include pharmacies, pharmacists, or opioid overdose education and naloxone distribution (OEND) programs. OEND programs may include law enforcement agencies, drug treatment programs, local health departments, hospitals or urgent care facilities, or other for-profit or not-for-profit community-based organizations that do not have access to a standing order through their organization.

Who should not use the Illinois Naloxone Standing Order?

Individuals should not use the standing order to fill naloxone prescriptions at a pharmacy. Instead, individuals should either obtain a prescription for naloxone from their prescriber, or go to a pharmacy that is using a naloxone standing order.

Opioid safety language

Communicating with patients about naloxone

The word "overdose" may have negative connotations and prescription opioid users may not relate to it.

Some patients have overdosed and don't realize it.

Out of 60 patients on opioid therapy for pain, 22 (37%) had stopped breathing or required help to be woken up due to opioids.[15]

45% *of these patients denied overdosing, calling it a bad reaction*

Instead of using the word "overdose," consider language like "accidental overdose," "bad reaction" or "opioid safety." You may want to say:

"Opioids can sometimes slow or even stop your breathing."

"Naloxone is the antidote to opioids – it can be used if there is a bad reaction where you can't be woken up."

"Naloxone is for opioid medication like an epinephrine pen is for someone with an allergy."

"Naloxone is important to have in the home in case someone is accidentally exposed to opioid painkillers."

Prescribing naloxone

Formulations

Intranasal

» Naloxone 4mg #1 two pack, use PRN for suspected opioid overdose

Auto-Injector

» Naloxone auto-injector 2mg #1 two pack, use PRN for suspected opioid overdose

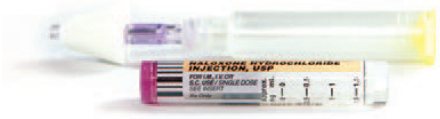
Devices designed for lay use can cut down on patient education. If the above devices are not optimal, prescriptions can be written for the following formulations and education should be provided directly to the patient.

Intranasal – assembly required

» Naloxone 2mg/2ml prefilled syringe #2, spray 1/2 into each nostril, use PRN for suspected overdose. Repeat if necessary.

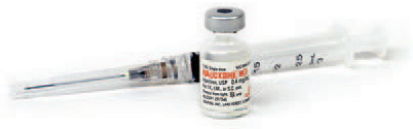
Note

Nasal atomizer generally not available through pharmacies



Injectable

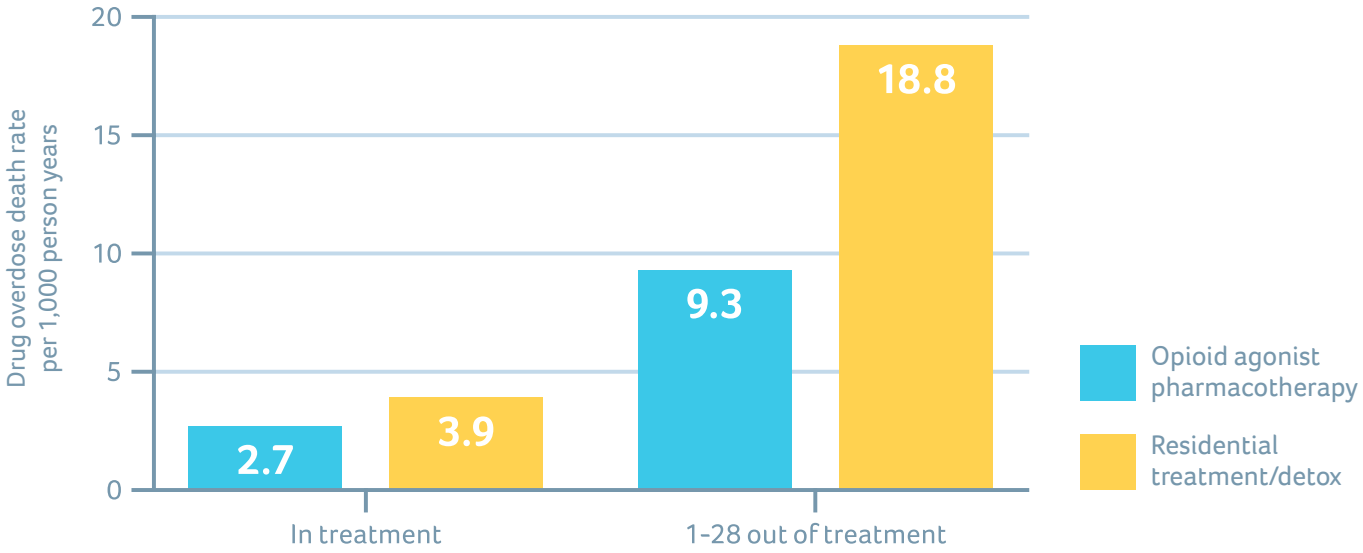
» Naloxone 0.4mg IM #2, use PRN for suspected overdose, IM syringe (3ml 25g 1" syringe) #2



Managing opioid use disorder

- If your patient has an opioid use disorder, it is essential to arrange for treatment.
- **Treatment with medications has the best evidence for managing opioid use disorder and should be considered for all patients with significant disease.**
- When therapy for opioid use disorder is stopped, the risk of death increases.

Drug overdose death rate per 1,000 person years among 151,983 people with opioid use disorder seeking treatment in the United Kingdom[16]



FDA-approved medication treatment options

- Buprenorphine (with or without naloxone)
- Methadone
- Extended-release naltrexone

A list of local community resources can be found in Epic in External Links - Easy Button.

Like treatment for other chronic diseases such as diabetes, these medications should be considered long-term therapy.

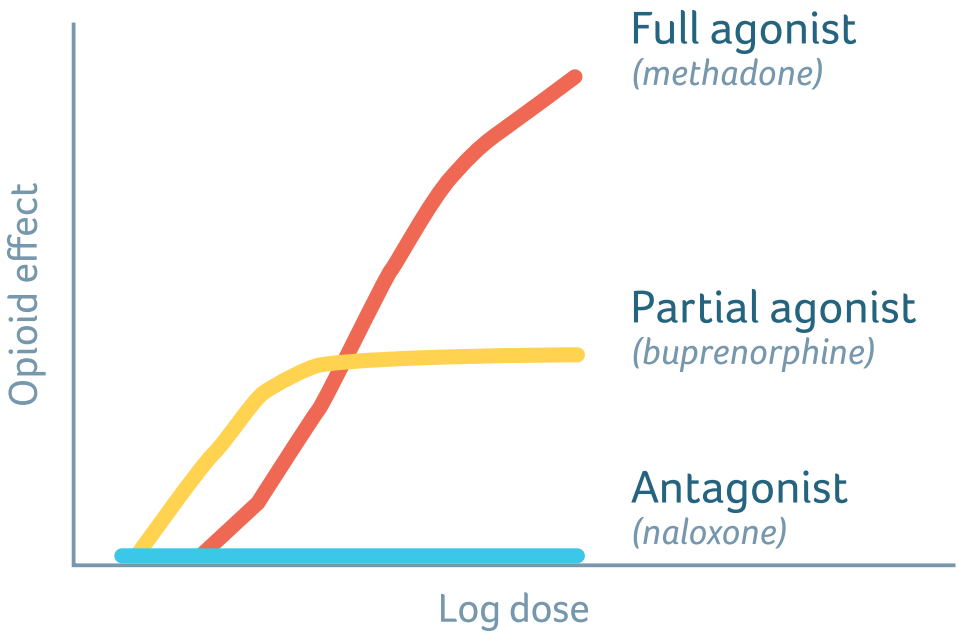
Behavioral/psychological treatment options

- Support groups such as Narcotics Anonymous
- Outpatient or inpatient rehabilitation and counseling

If not personally providing the treatment, a warm handoff to other providers is critical.

For more information regarding additional resources, visit www.dph.illinois.gov/opioids/treatment

Buprenorphine



Buprenorphine

- A partial opioid agonist
- Lasts 36 hours
- Has very high affinity, blocking effects of heroin or other opioids

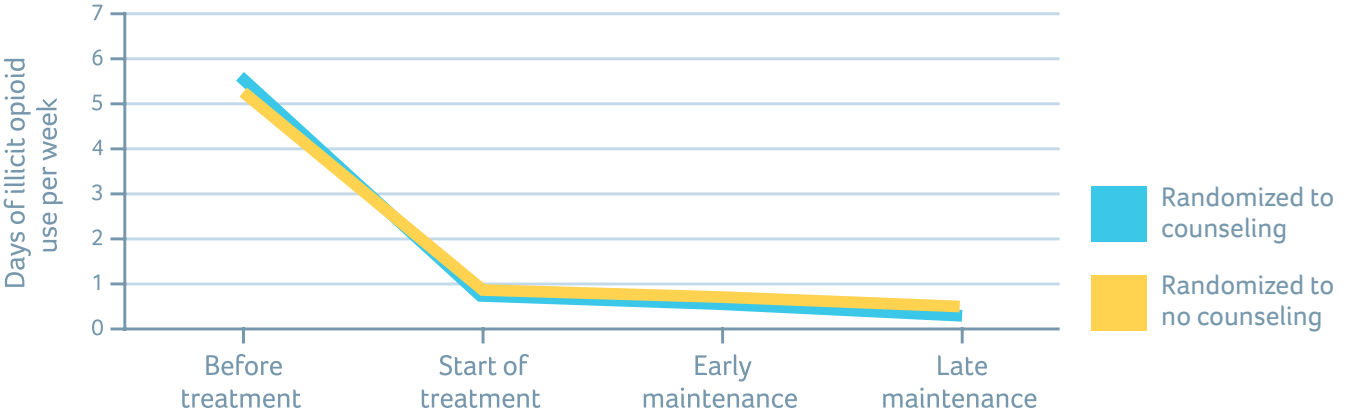
Safety profile

- Due to the "ceiling effect" of a partial agonist, buprenorphine has:
  - Low potential for misuse and diversion
  - Low risk of respiratory depression or overdose
- Maintenance is critical: opioid use disorder requires long-term care.
- Buprenorphine treatment is safe and effective during pregnancy.
- Most buprenorphine for opioid use disorder treatment is co-formulated with naloxone to discourage diversion or injection of the product.

Buprenorphine is an effective medication to treat opioid use disorder in primary care

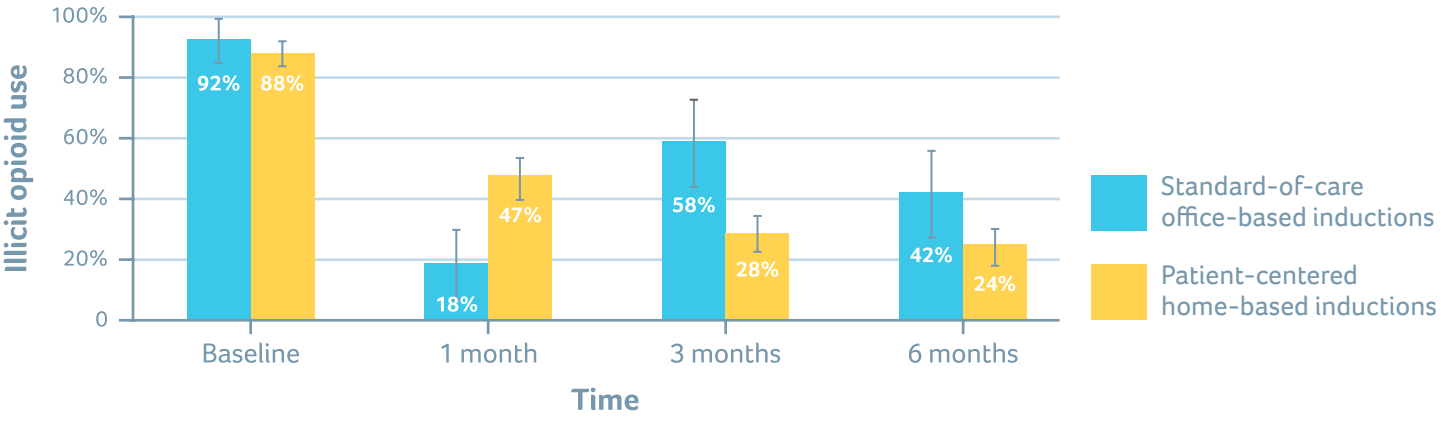
Routine medication management can be as effective as combining buprenorphine with counseling.

While counseling should be sought if available, lack of access should not be a barrier to treatment.[17]



Patients can be started on Buprenorphine in the office or at home.

Opioid use patterns are similar if patients start therapy themselves at home.[18]



In a randomized controlled trial of buprenorphine, patients who used only prescription opioids responded even better than those who used heroin (P<0.001).[19]

Buprenorphine reduces mortality...

Buprenorphine reduces mortality, possibly even more than methadone. [20]

	Methadone CMR (95%CI)	Buprenorphine CMR (95%CI)
First 4 weeks		
All-cause mortality	9.6 (6.5 - 13.5)	4.3 (2.0 - 8.2)
Drug related mortality	5.4 (3.2 - 8.5)	1.0 (0.1 - 3.4)
Remainder of treatment		
All-cause mortality	6.8 (6.3 - 7.4)	3.9 (3.1 - 4.9)
Drug related mortality	1.7 (1.4 - 2.0)	1.5 (1.0 - 2.1)

CMR = Crude Mortality Rate per 1,000 person years

...and pain

Studies support use of buprenorphine for chronic pain. [21]

In a study of 35 patients on 200-1,370 morphine equivalent milligrams of opioids for chronic pain, after two months of sub-lingual buprenorphine:

Pain scores reduced
from 7.2 to 3.5 (p<0.001)

Quality of life scores increased
from 6.1 to 7.1 (p=0.005)

Prescribing buprenorphine as maintenance treatment for opioid use disorder requires an "X" number

- An "X" number is a separate DEA registration number that must be used when buprenorphine is prescribed for opioid use disorder.
- After getting an "X" number, you can prescribe ≤30 patients in year 1 and ≤100 patients in subsequent years.
- MDs and DOs can apply to treat ≤275 patients after treating 100 patients for a year.

To obtain an "X" number

If you are a licensed MD or DO:

- Complete a free, 8-hour training (or have substance use disorder treatment experience).
  For more information:
  www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver
- Complete and submit a physician waiver.

If you are a licensed NP or PA:

- Complete a free, 24-hour training.
  For more information:
  www.samhsa.gov/medication-assisted-treatment/quality-nps-pas-waiver
- Complete and submit a physician waiver.

You will receive a second DEA registration card with your "X" number:

Prescribing buprenorphine ONLY for pain does NOT require an "X" number, but may require prior authorization.

How to prescribe buprenorphine

For opioid use disorder

- Most patients stabilize between 8-24mg (initial dose is generally 4-8mg).
- Medication is generally administered sub-lingually and daily.

For pain

- Any formulation can be used, including the transdermal patch.
- Prior authorization may be required.
- No "X" number required.
- Medication is generally administered 2-3 times daily.

Formulations

Standard for opioid use disorder:

- Coformulated buprenorphine/naloxone SL tablets.
- Coformulated buprenorphine/naloxone film or implant.

If patient does not tolerate/cannot access coformulated products:

- Monoformulated buprenorphine SL tablets.

If treating pain, may also consider:

- Monoformulated buprenorphine transdermal patch.

Additional non-pharmaceutical options for patients with chronic pain

Due to increased risk for various complications, patients with an opioid use disorder should also be considered for:

Additional Things to Try to Relieve Pain:

- Dimming lights
- Warm blankets
- Back rub
- Cold with warm washcloth

Items That May Make You More Comfortable:

- Ice pack
- Neck pillow
- Saline nose spray
- Warm blanket
- Extra pillow
- Mouth swab
- Warm/Cold compress
- Warm/Cold washcloth
- Pillow to raise your knees/ankles
- Essential Oils

Actions That May Make You More Comfortable:

- Repositioning
- Gentle stretching/range of motion
- Adjust lighting/noise level
- Walk in the hall
- Bath or shower
- Adjust bedding
- Dietary changes

Additional Options for Relaxation:

- Ear plugs
- Personal headphones
- Quiet/uninterrupted time
- Eye shield to block light
- Listen to music
- Visit from family/friends

Last Updated: 2.2019.

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The recommendations contained in this guide are general and informational only; specific clinical decisions should be made by providers on an individual case basis.

02.2020