Safe Pain Medication Prescribing Guidelines

DEVELOPED BY THE

San Diego County Medical Society Prescription Drug Abuse Medical Task Force

San Diego County Medical Society
"Physicians United for a Healthy San Diego"

Imperial County Medical Society

Imperial County California Public Health Department

County of San Diego HHSA Health and Human Services Agency

Hospital Association of San Diego and Imperial Counties

SAFE PAIN MEDICATION PRESCRIBING GUIDELINES

TABLE OF CONTENTS

Prescription drug abuse has been declared an epidemic by the Centers for Disease Control and Prevention (CDC). According to 2012 San Diego Medical Examiner data, the leading cause of non-natural death is drug overdose. Drug overdose deaths greatly exceed deaths due to motor vehicle crashes, and the majority involves prescription drugs.

The following guidelines are a collection of recommendations developed by the San Diego County Medical Society (SDCMS) Prescription Drug Abuse Medical Task Force, a group that includes representatives from Imperial County as well. They draw on published medical literature and the experience of various groups across the country. These are **guidelines**, not policies. Physician discretion is acknowledged in applying them.

These Safe Pain Medication Prescribing Guidelines have been developed by the San Diego County Medical Society Prescription Drug Abuse Medical Task Force, which includes members from the following medical community stakeholders:

- San Diego County Medical Society (SDCMS)
- Hospital Association of San Diego and Imperial Counties (HASDIC)
- San Diego County Health and Human Services Agency (HHSA)
- San Diego County Dental Society (SDCDS)
- San Diego Psychiatric Society
- San Diego Prescription Drug Abuse Task Force
- Kaiser Permanente San Diego
- Sharp Healthcare
- Scripps Health
- UC San Diego Health System
- Council of Community Clinics

SAFE PAIN MEDICATION PRESCRIBING GUIDELINES

A. CURES REPORTS

- The California database for controlled substances is the Controlled Substance Utilization Review and Evaluation System, CURES.
- To obtain access to the California Prescription Drug Monitoring Program (PDMP) System, you must register electronically.
- Realize that data in CURES may be delayed by up to two weeks and are not consistently uploaded by all pharmacies. The VA system and military treatment facilities do not upload data into CURES.
- You can arrange to sign up a large group of providers at one time by having DEA representative come to your location. Contact CURES office for details.

RETURN TO TABLE OF CONTENTS

B. PAIN ASSESSMENT

- It is common to document a pain scale for 1 to 10 according to the patient's assessment. It is helpful to include a functional description of any limitations on patient's activities due to pain.
- In an acute setting, describe patient's function and mobility.
- In the chronic setting, assess risks versus benefits for opioid prescribing with Screening Assessment Tools such as the McGill General Pain Disability Index, SOAPP-R, ORT Questionnaire, or others. See link on Screening and Monitoring Tools.

RETURN TO TABLE OF CONTENTS

C. ACUTE PAIN TREATMENT RECOMMENDATIONS

1. Dosing for Acute Pain:
   - Patients with acute pain and who require opioids should receive short-acting opioids, with the least number of pills needed to cover the time for pain recovery and to minimize potential diversion or sharing of medication.
   - In the emergent setting, prescribe only 10–15 tablets of a short-acting opioid.
2. Dosing for Opioid Naive Patients:
   - Start with a short-acting opioid with a maximum dose of 4 per times day.
   - Be careful not exceed recommended maximum for acetaminophen of 3000 mg per day.
   - TYLENOL #3 (30 mg codeine/300 mg acetaminophen)
     - 30 mg codeine = 3.6 mg hydrocodone = 3.6 mg oxycodone
   - VICODIN (hydrocodone/acetaminophen) — Use 5 mg
     - 5 mg hydrocodone = 27.5 mg codeine = 3.3 mg oxycodone
   - NORCO (hydrocodone / acetaminophen) — Use 5mg
   - LORTAB (hydrocodone/ acetaminophen) — Use 5mg
   - PERCOCET/ ENDOCET (oxycodone/acetaminophen) — Use 5mg
     - 5 mg oxycodone = 7.5 mg of hydrocodone = 41.3 mg codeine
     - Maximum of 8 tablets a day for 5 mg.
   - TRAMADOL/ULTRAM
     - Start with IR 50mg mg q 4–6 hours (Maximum 400 mg/day).

- Do not use if patient has liver disease, renal disease, is on a tricyclic antidepressant or SSRI medication.
- This medication has a high abuse potential.
- This medication does not show up on CURES reports and can be refilled, unlike the Vicodin or Percocet prescriptions.
- This is available OTC in Mexico.
- Deaths have been reported in patients with emotional disturbances and misuse of alcohol, tranquilizers, and other CNS active drugs.

3. Register for CURES and run a CURES report on patients who may have prescriptions from other sources to ensure you are not overprescribing.

RETURN TO TABLE OF CONTENTS

D. EMERGENCY DEPARTMENT PAIN TREATMENT

The SDCMS Emergency Medicine Oversight Commission has a consensus chronic pain prescription guideline.

RETURN TO TABLE OF CONTENTS

E. CHRONIC PAIN TREATMENT RECOMMENDATIONS

1. Who Should Sign a Pain Medication Agreement? It is recommended that the following patients sign a pain medication agreement:
   - Any patient on short acting opioid at time of third visit.
   - Any patient on long acting opioid.
   - Any patient expected to require more than 3 months of opioids.

   Note: A pain medication agreement was developed by the San Diego County Prescription Drug Abuse Medical Task Force, whose members are listed at the end of this document. This model agreement is available for your use.
2. Use the Flow Diagram for Chronic Pain Treatment
   - Click here for a flow diagram for general treatment recommendations.
3. Conduct a Pain Assessment Utilizing a Standard Tool / Opioid Risk Tool
   - There are various Tools available for Initial Assessment, upon initiating Pain Agreement, and for On Going Follow Up and Monitoring.
   - See Screening and Monitoring Tools.
4. Register / Run CURES Reports
   - It is recommended to review CURES data from previous 6 - 12 months at initial appointment for chronic pain treatment.
   - Review data for report of lost prescriptions, requests for early refills, escalating of pain, and at provider's discretion. Some pain specialists review data at each appointment.
5. Use Drug Screens
   - Use as an initial screening tool when considering prescribing an opioid.
   - Consider for all patients with a pain agreement at the time of initial pain evaluation, at 3 months, and randomly at your discretion considering each individual risk and benefit profile.

- Evaluate to see that prescribed medications are positive. If the patient is not positive for the medications prescribed then the medication is either (a) not being used safely such as overuse at the beginning of the month and running out early, or (b) being diverted.
- Evaluate for illegal drugs or drugs that were not prescribed.
- Note that the Pain Agreement devised by the San Diego County Prescription Drug Abuse Medical Task Force states that use of illegal drugs is grounds to discontinue pain medication and refer to addiction medicine or other appropriate specialist.

RETURN TO TABLE OF CONTENTS

F. CHRONIC PAIN DOSING RECOMMENDATIONS

1. Dosing For Patient Requiring Medication More Than 4 Times a Day.
   - If medication is required more than four times a day, refer the patient to pain management or switch to a long acting opioid with the starting doses below.
   - If a switch is made to a long acting opioid, the need to continue a short acting opioid could be considered for break through pain. Remember to consider the short acting opioid as part of the total dose and avoid using more than 4 times a day.
   - If there are frequent request for increases in doses or non-compliance, the patient should be referred to a pain specialist for treatment evaluation and plan.
   - Starting Doses are as follows:
   - Titration to long acting opioids can be difficult. It is best to start at lower doses and have a sooner follow up to evaluate effect and prevent complications. Numerous conversion tables are available, but always allow for cross-tolerance between medications. When rotating opioids, lower the new medication by at least 10-25%.
     - Morphine (12 hour release) 15 mg bid
     - Morphine (24 hour release) 30 mg per day
     - Fentanyl patch 12.5 mcq every 72 hours
     - Methadone 5 mg bid
     - Oxycodone 10 mg bid
2. Maximum Recommended Doses Prescribed by a Primary Care Provider for Chronic Benign Pain before Specialist Consultation.
   - Consider referral to a pain specialist or other appropriate specialist if the patient requires more than the following dosages:
     - Morphine 120 mg/day
     - Fentanyl patch 50 mcg/ 72 hours
     - Methadone 40 mg/day
     - Oxycodone 80 mg/day

G. WEANING OPIATES

- Opiates should be weaned and discontinued when the risks outweigh the benefits and when the patient is not maintaining or improving function.
- Patients treated for acute pain with opioids should be instructed to decrease their doses and discontinue as soon as possible.
- Patient on chronic opioids can be placed on a weaning protocol. One weaning protocol can be found on page 10 of the Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain.
- Opioid withdrawal symptoms are uncomfortable, but are not dangerous. Opioids can be stopped abruptly when the risks outweigh the benefits. This is not true for benzodiazepine withdrawal. Benzodiazepine withdrawals can be life threatening.

RETURN TO TABLE OF CONTENTS

H. SIDE EFFECT MANAGEMENT

1. Constipation
   - It is recommended to manage constipation proactively. You may want to prescribe a stool softener/laxative in conjunction with opioids, especially in the elderly population, as opioids will reduce gastric and intestinal motility.
2. Somnolence. Reduce dose of narcotic. Find out if the patient is taking excess medication, using alcohol, or mixing other medication, which increases risk of somnolence.

RETURN TO TABLE OF CONTENTS

I. CONCOMITANT PRESCRIPTIONS

1. Acetaminophen
   - Should not exceed more than 3 grams per day.
   - Patients with liver impairment should not exceed more than 2 g per day.
3. Benzodiazepines
   - Concomitant use of long acting narcotics and benzodiazepines is not recommended due to risk of mortality.
   - Taper benzodiazepines and consider psychiatric consultation if there is an anxiety component to the patient's perception of their pain.
4. Medical Marijuana
   - Concomitant use of marijuana is not recommended.
   - New patients who admit to using marijuana or who have a positive marijuana screen should not be given opiates unless they agree to discontinue marijuana
5. Phenergan
   - Concomitant use of Phenergan with codeine in a cough suppressant formulation is not recommended due to its recreation abuse potential as "Purple Fizz".
   - Use alternative nausea medications such as Reglan, Compazine, or Zofran.
6. Soma (Carisoprodol)
   - This medication should be avoided due to high potential for abuse and diversion.
   - An alternative muscle relaxant can be used such as Baclofen, Flexeril, Zanaflex, or Robaxin.
7. Barbiturates

- Avoid use due to additive sedation effects.
- Seroquel (Quetiapine)
- This medication has potential for abuse.

RETURN TO TABLE OF CONTENTS

J. RED FLAGS FOR PRESCRIPTION DRUG ABUSE AND FRAUD

Published by the CURES program

- Patient requesting specific controlled substances.
- Repeatedly running out of medication early.
- Unscheduled refills requested.
- Unwillingness to try non-opioid treatments.
- Engaging in doctor shopping activities.

RETURN TO TABLE OF CONTENTS

K. DEA REPORTING

- You are encouraged to report suspected doctor shopping and prescription fraud to the DEA. Prescription fraud includes being dishonest with how a medication is taken. If you suspect doctor shopping or diversion, please report to:
  DEA Diversion: (858) 616-4100
  Email to DEA: deatips-sandiego@usdoj.gov
  Name of Patient
  Date of Birth of Patient
  Location of Occurrence
  Suspicion
- It is helpful for DEA if you document the following in your medical record:
  - The date the patient stated he last received prescription for controlled substance and which doctor prescribed it.
  - A copy of the patient's ID card.
  - Patients who lie about when their last prescription was filled are guilty of narcotic fraud.
  - For patients who are argumentative, do NOT feel compelled to write an opioid prescription, even for a small amount. If you have any concerns for the patient's safety, document the interaction, and then call the DEA.
- If you are contacted by a DEA investigator who is evaluating a potential fraud, please cooperative with the investigation. They may have simple questions that are not time consuming to find out whether your patient has been doctor shopping or committing fraud. Their investigation may lead to court-mandated addiction treatment.

RETURN TO TABLE OF CONTENTS

L. ADDICTION REFERRALS

If you need to dismiss a patient for not honoring treatment agreements, consider this referral source for addiction: San Diego County Access & Crisis Line: (888) 724-7240. This 24/7 hotline can provide information about low cost or sliding scale residential and non-residential drug treatment services.

County of San Diego Health and Human Services Substance Abuse Referral Form

RETURN TO TABLE OF CONTENTS

M. EDUCATIONAL MATERIALS (Click Here to Access the Following)

- ASIPP Opioid Guidelines 2012 — Part I
- ASIPP Opioid Guidelines 2012 — Part II
- Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain (Agency Medical Director's Group 2010 Update)
- Screening and Monitoring Tools
- Six Opioid Safety Steps (SOS)
- PowerPoint on CDC and San Diego County Deaths From Prescription Drug Abuse
- Street Value of Prescription Medication
- San Diego Prescription Drug Abuse Report Card
- Dental Prescription Drug Abuse Information
- National Institute on Drug Abuse

RETURN TO TABLE OF CONTENTS