OKLAHOMA OPIOID PRESCRIBING GUIDELINES

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, mental and public health officials, and law enforcement personnel in Oklahoma and throughout the United States.[1, 2, 3]

Opioid Treatment for Acute Pain

1. Health care providers are encouraged to consider non-pharmacological therapies and/or non-opioid pain medications. Opioids should only be used for treatment of acute pain when the severity of the pain warrants that choice.
2. By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.
3. When opioids are started, providers should prescribe the lowest possible effective dose. Prescribe no more than a short course; most patients require opioids for no more than three days.
4. Avoid prescribing opioids to patients currently taking benzodiazepines and/or other opioids.
5. Patients should be counseled to store medications securely, never to share them with others, and to dispose of medications when the pain has resolved.
6. Long-acting or extended-release opioids should not be prescribed for acute pain.
7. Providers should provide screening, brief intervention, and referral to treatment, if indicated.
8. Continued opioid use should be evaluated carefully, including assessing the potential for abuse, if pain persists beyond the anticipated period of acute pain.
9. In general, health care providers should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

Opioid Treatment for Chronic Pain

1. Alternatives to opioid treatment should be tried, or previous attempts documented, before initiating opioid treatment for chronic pain.
2. By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.
3. A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain.
4. The health care provider should screen for risk of abuse or addiction before initiating opioid treatment.
5. Patients should be counseled to store medications securely, never to share them with others, and to dispose of medications when pain has resolved.
6. Long-acting or extended-release opioids are associated with an increased risk of overdose death, and should only be prescribed by health care providers familiar with their indications, risks, and need for careful monitoring.
7. A written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function.

Learn more: poison.health.ok.gov

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Oklahoma State Department of Health

8. The patient should be informed of the risks, benefits, and terms for continuation of opioid treatment, ideally using a written and signed treatment agreement. Consider co-prescribing naloxone for patients with increased risk of opioid overdose.

9. Opioids should be initiated as a short-term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life. The trial should begin with a short-acting opioid medication.

10. During the titration period, regular visits for evaluation of progress toward goals should be scheduled and the PMP should be checked more frequently.

11. Continuing opioid treatment should be a deliberate decision that takes into consideration the risks and benefits of chronic opioid treatment for that patient. Patients and health care providers should periodically reassess the need for continued opioid treatment, weaning whenever possible. A second opinion or consultation may be useful in making that decision.

12. Opioid treatment should be tapered or gradually discontinued if adverse effects outweigh benefits or if aberrant, dangerous, or illegal behaviors are demonstrated. Care should be taken when tapering opioid treatment, particularly in patients on higher dosages, the elderly, and patients who are pregnant. Abrupt discontinuation of opioids should be avoided.

13. Health care providers should consider consultation for patients with complex pain conditions, serious co-morbidities, mental illness, or a history or evidence of current drug addiction or abuse.

14. In general, health care providers should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

15. Health care providers 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.

Oklahoma Society of Interventional Pain Physicians | Oklahoma Board of Nursing

Resources

1. **Centers for Disease Control and Prevention. (2016).** *CDC Guideline for Prescribing Opioids for Chronic Pain.* Retrieved from https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed July 8, 2016.

2. **Oklahoma State Department of Health. (2013).** *Oklahoma Emergency Department (ED) and Urgent Care Clinic (UCC) Opioid Prescribing Guidelines.* Retrieved from https://www.ok.gov/health2/documents/UP_Oklahoma_ED-UCC_Guidelines.pdf**.** Accessed July 8, 2016.

3. **Oklahoma State Department of Health. (2014).** *Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting.* Retrieved from https://www.ok.gov/health2/documents/UP_Oklahoma_Office_Based_Guidelines.pdf. Accessed July 8, 2016.

2017

Learn more: poison.health.ok.gov

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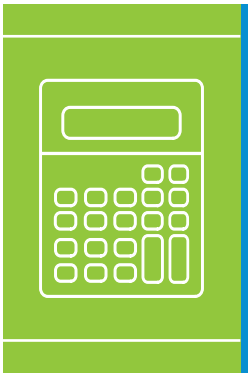
ASSESSING BENEFITS AND HARMS OF OPIOID THERAPY

Assess Benefits Of Opioid Therapy

Assess your patient's pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and **assess pain using validated instruments such as the 3-item PEG Assessment Scale:**

1. **What number best describes your pain on average in the past week?** (from 0=no pain to 10=pain as bad as you can imagine)
2. **What number best describes how, during the past week, pain has interfered with your enjoyment of life?** (from 0=does not interfere to 10=completely interferes)
3. **What number best describes how, during the past week, pain has interfered with your general activity?** (from 0=does not interfere to 10=completely interferes)



If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids. Continue opioids only as a careful decision by you and your patient when improvements in both pain and function outweigh the harms.

Assess Harms Of Opioid Therapy

Long-term opioid therapy can cause harms ranging in severity from constipation and nausea to opioid use disorder and overdose death. Certain factors can increase these risks, and **it is important to assess and follow-up regularly to reduce potential harms.**

1. **ASSESS:** Evaluate for factors that could increase your patient's risk for harm from opioid therapy such as:
   - Personal or family history of substance use disorder
   - Anxiety or depression
   - Pregnancy
   - Age 65 or older
   - COPD or other underlying respiratory conditions
   - Renal or hepatic insufficiency

2. **CHECK:** Consider urine drug testing for other prescription or illicit drugs and check the Oklahoma Prescription Monitoring Program (PMP) for:
   - Possible drug interactions (such as benzodiazepines)
   - High opioid dosage (≥50 MME/day)
   - Obtaining opioids from multiple providers

3. **DISCUSS:** Ask your patient about concerns and determine any harms they may be experiencing such as:
   - Nausea or constipation
   - Feeling sedated or confused
   - Breathing interruptions during sleep
   - Taking or craving more opioids than prescribed or difficulty controlling use

4. **OBSERVE:** Look for early warning signs of overdose such as:
   - Confusion
   - Sedation
   - Slurred speech
   - Abnormal gait

If harms outweigh any experienced benefits, work with your patient to reduce dose, or taper and discontinue opioids and optimize nonopioid approaches to pain management.

Learn more: poison.health.ok.gov

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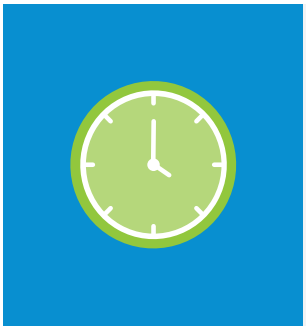
Tapering And Discontinuing Opioid Therapy

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea and tremors.
Tapering plans should be individualized. However, in general:



1. Go Slow

To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).

2. Consult

Work with appropriate specialists as needed — especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.

3. Support

During the taper, ensure patients receive psychosocial support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

Learn more: poison.health.ok.gov

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NONOPIOID TREATMENTS FOR CHRONIC PAIN

Principles of Chronic Pain Treatment

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies, can provide relief to those suffering from chronic pain and are safer.

Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

Medication	Magnitude of Benefits	Harms	Comments
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants (TCAs) and serotonin/ norepinephrine reuptake inhibitors (SNRIs)	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications:

- First-line: Acetaminophen, oral nonsteroidal anti-inflammatory drugs (NSAIDs), topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications:

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: Tricyclic antidepressants (TCAs), gabapentin

Neuropathic pain

Medications:

- TCAs, serotonin and norepinephrine reuptake inhibitors (SNRIs), gabapentin/pregabalin, topical lidocaine

Low Back Pain

Self-care and education in all patients: Advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications:

- First-line: Acetaminophen, NSAIDs
- Second-line: SNRIs, TCAs

Migraine

Preventive treatments:

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Nonpharmacological treatments (cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments:

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans (migraine specific)

Learn more: poison.health.ok.gov

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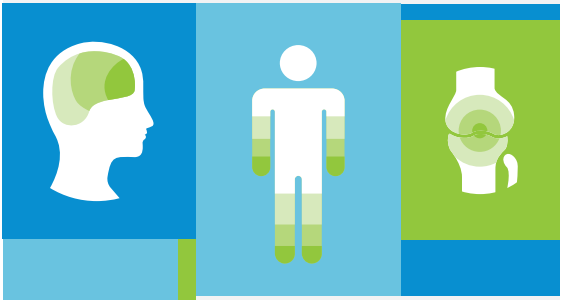
Pocket Guide: Tapering Opioids for Chronic Pain

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications.



Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to a lower dosage or discontinued.

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Learn more:
poison.health.ok.gov

When To Taper

Consider tapering to a **reduced opioid dosage or tapering and discontinuing opioid therapy** when your patient:

- requests dosage reduction
- does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale)
- is on dosages ≥ 50 MME*/day without benefit or opioids are combined with benzodiazepines
- shows signs of substance use disorder (e.g., work or family problems related to opioid use, difficulty controlling use)
- experiences overdose or other serious adverse event
- shows early warning signs for overdose risk such as confusion, sedation, or slurred speech

*morphine milligram equivalents

Recommendations focus on pain lasting longer than 3 months or past the time of normal tissue healing, outside of active cancer treatment, palliative care, and end-of-life care.

How To Taper

Go Slow: A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.

Consult: Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

Support: Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.

Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage: Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

Tell patients “I know you can do this” or “I’ll stick by you through this.”

Considerations

Adjust. Monitor. Reduce.

1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

Resources

Oklahoma Opioid Prescribing Guidelines
https://www.ok.gov/health2/documents/Oklahoma_Opioid_Prescribing_Guidelines_2017.pdf

CDC Guideline for Prescribing Opioids for Chronic Pain
www.cdc.gov/drugoverdose/prescribing/guideline.html

Washington State Opioid Taper Plan Calculator
http://www.agencymeddirectors.wa.gov/opioiddosing.asp

Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain
www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

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Learn more:
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Prescription Monitoring Program FAQs

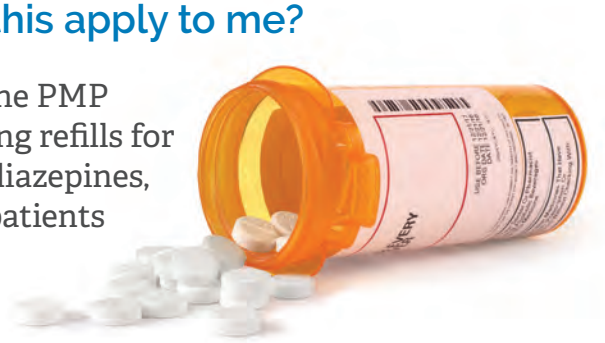
Frequently Asked Questions

What is the Prescription Monitoring Program (PMP)?

The Oklahoma PMP, also known as PMP AWARxE, is an electronic database that tracks controlled substance prescriptions in the state. The PMP gives health providers timely information about prescribing and patient behaviors, which improves clinical decision making. The PMP also reduces doctor shopping and diversion of controlled substances and allows for improved public health surveillance to monitor prescribing trends. The PMP is housed at the Oklahoma Bureau of Narcotics and Dangerous Drugs Control and leads other states as the only real-time system in the nation.

Q. If I only write a couple scripts per year, does this apply to me?

A. By Oklahoma law, it is mandatory that providers check the PMP prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol (exclusions for hospice or end-of-life, or patients residing in a nursing facility). This applies whether you write one or several thousand scripts per year.



Q. Do I need to check the PMP when discharging a patient from the hospital or emergency room?

A. If you are writing a prescription for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol at discharge from either event, you still need to check the PMP if it has been at least 180 days since you checked that patient.

Q. What if I only see the patient one time as a courtesy because his/her physician was not available?

A. This patient is new to you. If you make the medical decision to write a prescription for one of the medications listed in the law, it is still your responsibility to check the PMP.

Q. What if I stopped dispensing medication from my office so I would not have to do this?

A. Dispensing and writing prescriptions are two different activities. If you dispense from your office, you have to report Schedule II-V drugs to the PMP. If you have stopped dispensing, then you are probably writing the prescription and handing it to the patient to have it filled at a pharmacy. You still are required to check that patient in the PMP.

OKLAHOMA OVERDOSE PREVENTION

Q. I do not have time to use the PMP; do I still have to register?

A. As long as you are not writing a prescription for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol, then you are not required to register.

Q. What if I want to prescreen a potential new employee before I hire them?

A. Not allowed. That is considered misuse of the PMP and could cause you to lose your access. The PMP can be used to prescreen potential new patients. Providers must have established a physician/patient relationship prior to checking the PMP. Scheduling an appointment is considered establishing a physician/patient relationship.

Q. Why does my co-worker have different states listed to run patient searches?

A. Each state has specific statutes on who can have access to their state PMP. By that state statute, you may not be authorized to have access.

Q. How can I register for an account?

A. If you do not currently have a PMP account, you can register online on the PMP website, **https://oklahoma.pmpaware.net/login.**

Q. Can I allow office staff to perform the patient search?

A. Physicians may designate a staff member to run the patient PMP on the physician's behalf. This designated staff member must have their own PMP AWARxE account and have the physician listed as their supervisor.

Q. As a prescriber, how often do I need to check the PMP?

A. You are required by law to check the PMP prior to prescribing to new patients and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol (exclusions for hospice or end-of-life, or patients residing in a nursing facility).

Q. Can my office/facility have one username and password?

A. No. Everyone must have their own unique username and password.

Q. Who do I contact about PMP-related questions?

A. Call the Oklahoma Bureau of Narcotics and Dangerous Drugs Control helpdesk at **(877) 627-2674** or visit **pmp.obn.ok.gov.**

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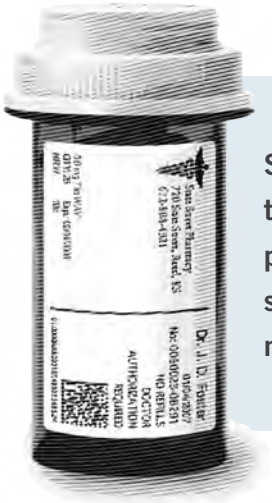
CDC OPIOID PRESCRIBING GUIDELINE MOBILE APP

Safer Opioid Prescribing at Your Fingertips

THE OPIOID GUIDE APP

Opioids can have serious risks and side effects, and CDC developed the CDC Guideline for Prescribing Opioids for Chronic Pain to encourage safer, more effective chronic pain management. CDC's new Opioid Guide App makes it easier to apply the recommendations into clinical practice by putting the entire guideline, tools, and resources in the palm of your hand.

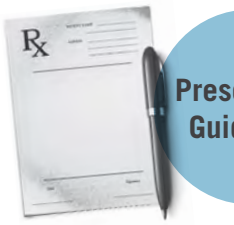


Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled.

FEATURES INCLUDE:

MME Calculator

Patients prescribed higher opioid dosages are at higher risk of overdose death. Use the app to quickly calculate the total daily opioid dose (MME) to identify patients who may need closer monitoring, tapering, or other measures to reduce risk.



Prescribing Guidance

Access summaries of key recommendations or link to the full Guideline to make informed clinical decisions and protect your patients.

Motivational Interviewing (MI)

To provide safer, more effective pain management, talk to your patients about the risks and benefits of opioids and work together towards treatment goals. Use the interactive MI feature to practice effective communication skills and prescribe with confidence.

MANAGING CHRONIC PAIN IS COMPLEX, BUT ACCESSING PRESCRIBING GUIDANCE HAS NEVER BEEN EASIER.

Download the free Opioid Guide App today!

www.cdc.gov/drugoverdose/prescribing/app.html

Available on the App Store

ANDROID APP ON Google play

This App, including the calculator, is not intended to replace clinical judgment. Always consider the individual clinical circumstances of each patient.

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Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html