**Summary**

- Add analgesic intensity for severe intractable pain.
- Ensure patient safety, prevent complications/morbidity.
- Establish realistic expectations.
- Monitor for appropriate use & meaningful improvement.
- Taper and discontinue if benefits do not outweigh risks.

**Decision Support**

- Opioids are not the preferred treatment for chronic pain.
- In select patients, opioids may be considered in combination with non-pharmacologic treatments and non-opioid medication.
- Always use caution when prescribing opioids and prescribe the lowest effective dose; increased dose = increased risk.
- Ongoing monitoring for risk/benefit is essential.

**Alerts**

*This care guide is the final part of a 3-part series of care guides for pain management. Its content is based on the 2016 Centers for Disease Control and Prevention (CDC) Guidelines for Prescribing Opioids (See Attachment G), and cumulative evidence demonstrating limited utility for opioid use in most chronic, non-cancer pain. Exceptions are made for clinical scenarios involving active cancer treatment, palliative care, and hospice. In all cases, the use of opioids should not be considered before completing a thorough pain assessment and initiating/optimizing non-opioid therapies as described in the CCHCS Pain Management: Part 1 & 2 Care Guides.*

---

**Patient Selection Criteria:**

1. Biomedical diagnosis with evident indication for opioids (primarily somatic pain).
2. Non-opioid and non-pharmacologic treatment have been trialed or are being trialed concurrently.
3. Pain is severe enough to interfere significantly with daily function.
4. Patient is not at high risk for opioid-related harm (see page 4).
5. Patient is compliant with assessment and monitoring including urine drug testing (UDT).
6. Patient able to engage in goal setting, understand the potential adverse effects and risks, and sign informed consent.

---

**Goals**

**Evaluation/Patient Selection**

**Patient Selection Criteria:**

1. Biomedical diagnosis with evident indication for opioids (primarily somatic pain).
2. Non-opioid and non-pharmacologic treatment have been trialed or are being trialed concurrently.
3. Pain is severe enough to interfere significantly with daily function.
4. Patient is not at high risk for opioid-related harm (see page 4).
5. Patient is compliant with assessment and monitoring including urine drug testing (UDT).
6. Patient able to engage in goal setting, understand the potential adverse effects and risks, and sign informed consent.

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**Treatment**

**Opioid Selection:**

1. New prescriptions for any controlled medication (CII-V) are limited to 7 days and must be re-evaluated before continuing. Most opioid use in the acute/trauma setting will require less than 7 days of therapy.
2. Initial opioid selection should be an immediate release agent of low potency (e.g., codeine, tramadol).
3. More potent opioids (e.g., morphine) should be used as second line agents.
4. Long-acting/extended release opioid preparations should be used only after initial titration with immediate release agent AND if the opioid therapy is intended to last more than 3 months (i.e., for severe, intractable pain).

**Chronic Opioid Initiation:**

1. Assure that initial UDT is consistent with therapy.
2. Set goals that are primarily function-based using the Specific, Measurable, Achievable, Relevant and Time-based (SMART) method.
3. Discuss the short-term benefits, potential side effects, risks, and the potential loss of efficacy over time.
4. Avoid co-prescription of sedative agents, especially benzodiazepines [CDC Recommendation #11].
5. Agree on duration of the trial (typically 2-3 weeks at optimal dose).
6. Discuss how opioids will be discontinued if they do not produce benefits that outweigh risks.
7. Target dose 0-50 Morphine Milligram Equivalents (MMEs); aim to keep dose under 90 MME. If larger doses are required, strongly consider an interdisciplinary case conference to discuss the patient.

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**Monitoring**

Schedule a follow-up visit within 7 days when initiating opioids, then every 1-4 weeks with any dose change; may gradually increase follow-up interval to maximum of every 3 months if no dose change and the patient is clinically/functionally stable. At each follow-up visit assess:

1. Progress towards, or maintenance of, functional treatment goals.
2. Adherence to all aspects of treatment plan.
3. Evident adverse effects or aberrant behaviors.
4. Complications or co-morbid conditions (e.g., mental health or medical conditions, emerging opioid use disorder)

**Complete Risk Mitigation Strategies:**

1. Order random surveillance UDT.
2. Provide education on overdose protection.
3. Repeat assessment tools e.g., Clinical Opiate Withdrawal Scale (COWS) (Attachment E), and Patient Health Questionnaire-9 (PHQ-9) (Attachment A).

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*Information contained in the Care Guide is not a substitute for a health care professional’s clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to “Disclaimer Regarding Care Guides” for further clarification. http://www.cchcs.ca.gov/careguides.aspx*
3. Opioids for Chronic Pain

Patient presents with severe chronic pain despite thorough efforts to optimize function with non-pharmacologic and non-opioid therapies
(Refer to CCHCS Care Guide: Pain Management Part 2—Therapy—Non-Opioid)

Patient Selection/Risk Assessment

- Complete PHQ-9, SOAPP, COWS, and other risk assessment criteria on pages 3-4 to determine patient’s risk for opioid-related harms or if contraindications for their use are present
- Order initial UDT

Patient Selection/Risk Assessment

- + Opioid or other Substance Use Disorder (SUD)
- PHQ-9 ≥ 15; Suicide risk
- SOAPP ≥ 7
- Co-Morbid OSA, COPD, Hepatic, Renal Disease, pregnancy
- + UDT for illicit substances or non-prescribed meds
- Non-adherence with clinic attendance or engaging in therapy
- Age >65
- Custody status
- Prior opioid therapy ≥ 90 MME
- Use of psych medications

Risks Outweigh Benefits
If on opioids, taper/discontinue Manage with non-opioid modalities

Opioid Treatment

Complete Informed Consent for Treatment with Opioid Medication (CDCR 7474)

- Initiate/Continue Opioid Therapy
- Start low and titrate slowly. New prescription limited to 7 days.
- Identify/use lowest effective dose
- Use IR over ER on new starts
- Monitor closely during initial dose titration

Monitoring

If patient is experiencing clinically significant functional improvement with minimal adverse effects:
Continue Opioid Therapy

Review and optimize comprehensive pain management plan including self-management strategies and non-opioid treatment
Follow-up frequently based on patient risk:
- See every 1-4 weeks with any dose/preparation change
- Up to every 3 months if no changes and patient is clinically and functionally stable
At each follow-up visit assess:
- Progress towards or maintenance of functional treatment goals
- Adherence to all aspects of treatment plan
- Adverse effects
- Complications or co-occurring conditions (MH, medical, SUD)
- Complete risk mitigation strategies
- Order random UDT (see pages 11-12 for UDT frequency and algorithm)
- Provide education on overdose prevention
- Repeat surveillance tools (COWS, PHQ-9)

If ordering continuation of opioid medication at time of parole, see page 7.

Emergence of Factors that indicate increased risk

- Non-adherence to comprehensive pain care plan
- Unexpected UDT results (see p. 13 for UDT interpretation)
- New mental health, medical, or SUD co-morbidities identified

If patient wants to proceed despite risks

If patient does not want to proceed with opioid therapy consideration, manage with non-opioid modalities

Provide medical and psychiatric treatment to stabilize as indicated

Ensure patient understands importance of balanced treatment approach. This includes:
- Optimizing non-opioid therapy
- Learning active self-management strategies
- Having clear goals established
- Understanding the risks, benefits, and limitations of opioids
Patient Selection/Risk Assessment

Improving the way opioids are prescribed, including careful screening of patients prior to treatment can ensure patients have access to safer, more effective chronic pain treatment while reducing opioid-related morbidity and mortality. Clinical discretion remains an essential component to reducing misuse and diversion, and providers must assess a range of external information, including patient drug utilization, drug screens, and information provided by the patient or others. To effectively screen the patients ensure the following are done:

1. Biomedical diagnosis with evident indication for opioids (primarily somatic pain)
   - It is presumed you have done a complete patient assessment based on Part 1 of the Pain Management Care Guides and have determined an underlying etiology characterized by the predominance of somatic type pain.
   - You should not consider opioid therapy for any patient for whom you have not done a complete assessment. For patients that transfer to your care already on opioids, it is essential to reassess the indications for continuation of opioids. New and emerging evidence is that there is a limited role for opioids in chronic, non-cancer pain. Examples of conditions for which opioids do not have good support include, but are not limited to: osteoarthritis, fibromyalgia, mechanical back or neck pain, and headaches.

2. Non-opioid & non-pharmacologic treatment have been trialed or are being trialed concurrently
   - Multimodal therapy is generally superior to any one therapy used alone. Opioid therapy should never be used in isolation of other non-opioid therapies. (Refer to Pain Management Part 2—Therapy—Non-Opioid Care Guide).

3. Pain is severe enough to interfere significantly with daily function
   - Understanding the extent of pain-related functional impact will factor into selecting patients appropriate for opioid therapy and serves as a basis for setting goals for therapy.

4. Patient is not at high risk for opioid-related harm [CDC Recommendation #8]
   - Conditions that increase your patient’s risk for harm from opioid therapy include:

<table>
<thead>
<tr>
<th>Obstructive Sleep Apnea, COPD</th>
<th>Benzodiazepine/psych medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of significant hepatic or renal compromise</td>
<td>Custody status</td>
</tr>
<tr>
<td>Depression, Anxiety, PTSD, Borderline, Antisocial Personality</td>
<td>History of drug overdose</td>
</tr>
<tr>
<td>History of diversion of controlled substance</td>
<td>Prior opioid therapy &gt; 90 MME</td>
</tr>
<tr>
<td>Positive UDT for illicit substance</td>
<td>Age &gt; 65 or &lt; 30</td>
</tr>
<tr>
<td>Psychiatric instability or intermediate to high acute suicide risk</td>
<td>History of SUD</td>
</tr>
</tbody>
</table>

Risk Assessment Tools to be utilized (see Ad Hoc charting in EHRS):

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Used For</th>
<th>Completed By</th>
<th># of Items</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9</td>
<td>All patients with chronic pain given high rates of comorbid depression</td>
<td>Patient</td>
<td>9</td>
<td>Range 0-27 (higher = worse depression) 0-4=None; 5-9=Mild; 10-14=Moderate; 15-19=Moderately Severe; 20-27=Severe</td>
</tr>
<tr>
<td>NIDA Quick Screen</td>
<td>Determining if there is previous or active substance abuse</td>
<td>Provider</td>
<td>1 repeated 4 times</td>
<td>In the past year how often have you used the following? Any YES responses, proceed to NIDA Modified Assist Tool (Attachment C)</td>
</tr>
<tr>
<td>NIDA Modified Assist</td>
<td>Patients at risk for prescription drugs/illegal drugs</td>
<td>Provider</td>
<td>8</td>
<td>Lower Risk 0-3 Moderate 4-26 High Risk &gt;27</td>
</tr>
<tr>
<td>Screener &amp; Opioid Assessment for Patients with Pain (SOAPP)</td>
<td>Patients who are being considered for long-term opioid therapy</td>
<td>Patient</td>
<td>14</td>
<td>Self-administered by the patient for follow-up visits</td>
</tr>
<tr>
<td>Clinical Opiate Withdrawal Scale (COWS)</td>
<td>Characterizing misuse once opioid treatments begin</td>
<td>Provider</td>
<td>11</td>
<td>5-12=Mild; 13-24=Moderate; 25-36=Moderate-Severe; &gt;36=Severe Withdrawal</td>
</tr>
</tbody>
</table>
5. Patient is not at high risk for opioid-related harm [CDC Recommendation #8]

Risk Assessment Tools
- **PHQ-9 depression screen** discussed in Pain Management Part 1—Assessment Care Guide.
- **NIDA substance use screen** (Attachment B) discussed in Pain Management Part 1—Assessment Care Guide.
- **Screener and Opioid Assessment for Patients with Pain (SOAPP)** (Attachment D).
  - A tool for clinicians to help determine level of risk for developing problems related to taking opioids.
  - Higher risk = higher level of monitoring required if placed on long-term opioid therapy.
  - Useful to have done at initial assessment and at any transition in circumstance (e.g., change in institution).
  - Should be completed BEFORE considering initiating opioids.
- **Clinical Opiate Withdrawal Scale (COWS)** (Can be found in the Ad hoc section of EHRS)
  - 11 item scale to be completed by a clinician.
  - Designed to rate common signs and symptoms of opiate withdrawal and assess the level of physical dependence on opioids.
  - Symptoms of opioid withdrawal have been noted to appear like a severe flu infection (i.e., nausea, vomiting, sweating, joint aches, agitation, shakiness).
- **Assure patient does not have evident Substance Use Disorder (SUD) using the above tools**
  - SUD is defined as a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12-month period:
    - Use of larger amounts/longer period of time than intended
    - Much time spent using
    - Neglect of work, school, or home in order to use
    - Activities given up to use
    - Use in hazardous situations
    - Physical/psychological problems related to use
    - Repeated attempts to quit/control use
    - Interpersonal problems related to use
    - Craving
    - Tolerance
    - Withdrawal
  - If the patient has: 2-3 Criteria – risk for SUD is Mild; 4-5 – Moderate; ≥ 6 – Severe [CDC Recommendation #12]

6. Patient is compliant with assessment including UDT
- Patients who are unwilling or unable to comply with a treatment plan should not be placed on opioids because of the increased risk for opioid-related harm.
- Refusal of clinical assessment and/or UDT is a contraindication for opioids.
- If the patient is already on opioids, such refusal should trigger taper or discontinuation depending on the circumstance and at the provider’s discretion.
- The consequences for such behavior is clearly stated in the informed consent for opioid therapy. (See CDCR form 7474) (Attachment H).

7. Patient is able to engage in goal setting, understand the potential adverse effects and risks, and sign informed consent
- Set realistic goals for pain and function based on diagnosis (Refer to Pain Management Part 2—Therapy—Non-Opioid Care Guide for tips in creating SMART goals) [CDC Recommendation #2].
- Discuss benefits, side effects, and risks of opioid therapy.
- Set criteria for stopping, or continuing and regular progress assessment.
- Check patient understanding about treatment plan (effective communication).
- The opioid therapy informed consent has 3 distinct sections to facilitate meeting these criteria:
  1) Discussion of risks and possible adverse effects; [CDC Recommendation #3]
  2) Criteria for opioid initiation and continuation; and
  3) Conditions for discontinuation.
- The consent should be renewed every time there is a change of primary care provider and/or change in institution.
## Changing the Conversation - Communication Tips for Discussing Opioid Therapy

A conversation is challenging when you are:
- Denying opioids to a patient who specifically requests them.
- Informing a patient that continuing their long-term opioid medication must be tapered and discontinued because risks of opioid therapy are outweighing benefits.
- Informing a patient that their UDT shows illicit drugs and their opioid prescription will be tapered and discontinued because risks of opioid therapy are outweighing benefits.

Outside Medical Groups, including the VA, are trying to help providers prepare for these difficult conversations and present a consistent message. Here are some conversation hints to consider:

### When the conversation starts with: | Instead of saying this: | Try saying this:
---|---|---
Patient requests morphine for chronic low back pain | CDCR says I cannot prescribe morphine any longer. We will need to use something else. | We have new information showing that opioids like morphine are not the best treatment for back pain.
Patient requests a higher dose of opioid | I know you have pain, but I cannot give you more hydrocodone and really we should not be using it at all. | Can I talk to you about other treatments that might work better for your pain and are safer in the long run?
Patient on methadone for chronic pain over the past 3 years and wants to continue | I am going to reduce your dose slowly over the next couple of months. | We are realizing that opioids are not the best option for treating chronic pain. Your injury is long past healed; let’s slowly taper the methadone and see how you do.
Patient returns for follow-up after CTEC discussion | The committee said no more opioids, so I need to discontinue. | It’s looking like the benefits of morphine are not outweighing the risks it is posing and I want to begin a taper. I want to see you more often during this process to assure things go smoothly and we can look at other therapies to help with your pain.
Repeated requests for opioids | For the 10th time NO, I don’t want to discuss this anymore. | Your repeated requests for opioids with no interest in considering other options has me concerned that you may be suffering from addiction – would you like to consider treatment for substance use disorder?

Adapted from Table 1. Starting the Conversation with Veterans About Opioid Safety. Reprinted and adapted from Transforming the Treatment of Chronic Pain, Moving Beyond Opioids, by U.S. Department of Veterans Affairs, May 9, 2018, retrieved from [https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_ChronicPainProviderEducationalGuide_IB101000.pdf](https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_ChronicPainProviderEducationalGuide_IB101000.pdf)
Published August 2017.

### Techniques For Challenging Patients:
Maintaining a therapeutic relationship in the context of difficult conversations can be extremely challenging, especially when there is underlying pathology such as SUD and/or borderline personality disorder (BPD). For example, the wild shift between idealization and devaluation, typically found in BPD, is known as splitting, which signifies a disturbance in both thinking and emotion regulation. Idealization, devaluation, and splitting are considered to be subconscious defense mechanisms by which people view others, events, or even themselves as a way to protect themselves from perceived stress. When such defense mechanisms are consistent, distorted, and accompanied by other symptoms/behaviors including, but not limited to, acting out, denial, and passive aggression, be sure to consult with mental health. See page 6 for some sample techniques.
Changing the Conversation - Communication Tips for Discussing Opioid Therapy (Continued)

While there are no easy answers for how best to deal with behaviors that manifest from subconscious defense mechanisms (such as splitting or devaluation), be alert to the possibility you are dealing with a personality disorder and get help. In addition, be mindful of your own responses and behaviors. Here are some guiding principles:

- **Cultivate empathy.** Remember that devaluing is part of the disorder. While certain actions may seem intentional and manipulative, these are simply defense mechanisms.
- **Manage your response.** Remember that you are in the better position to control your temper. Yelling or engaging in hostility will only serve to make the situation worse.
- **Remind your patient that you care.** Knowing that someone cares often helps reduce the devaluing behavior because it lessens the fear of being rejected or abandoned.
- **Maintain lines of communication.** Discuss isolated situations as they happen. Failure to communicate only serves to fuel rejection anxiety.
- **Set boundaries.** Always set limits. Use the principles of the opioid agreement (even if you are not prescribing opioids) to establish expectations for behaviors. If a boundary is crossed, explain why you are proceeding as you are and try to do so dispassionately. Setting boundaries helps preserve the relationship rather than challenging it.
- **Encourage and support treatment.** Your patient may do better with treatments including medications and behavioral therapies (both cognitive and dialectical).
- **Take care of yourself.** Remember to engage with your peers and others for support. This is difficult work and you are not alone.

**Documentation**

- Be sure to document your assessment and significant findings in the progress notes.
- Any signs of aberrant behavior such as hoarding, overdose, diversion, or refusal of exams, as well as abnormal UDT should be documented in the progress notes and the problem list as well.
- When you are using opioid therapy, your assessment should include a statement linking your action to your weighing the risks and benefits of therapy.
- Always consider the possibility of a transfer and the importance of communicating with your colleagues.

Complex Patient Case Discussion/Clinical Team Education Conference (CTEC)

(Formerly Known as Pain Committee)

- Consider scheduling a CTEC or interdisciplinary Complex Patient Case Discussion to review pain management issues of interest or to discuss patients with complex chronic pain care needs.
- Representation should be multidisciplinary and include medical, mental health, pharmacy, nursing, and custody whenever relevant.
- The purpose of CTEC is primarily educational and can be very useful in the deliberation of specific complex case management when, for example:
  - Opioid dosing > 90 MME.
  - Suicide threats made linked to pain treatment.
  - Patients identified as HIGH RISK for opioid use but who the PCP still wishes to consider opioid therapy.
  - Many other circumstances where there is conflict or perceived challenge.
- When there are deliberations regarding the clinical care of a specific patient, a medical chart entry should clearly and accurately reflect the committee’s findings and recommendations.
- **NOTE:** These meetings are explicitly advisory in nature. It is the PCP’s responsibility to enact recommendations of the interdisciplinary team or to act in an alternate fashion based on their clinical discretion and the welfare of the patient. It is the medical leadership’s role to consult with providers ordering therapies, including medications, contrary to applicable standards of care for best practices as espoused by guidelines and colleague’s recommendations.
- To schedule a CTEC for Pain Management Specialist input, send requests to the Pain Management warm line at: CCHCSPainManagement@cdcr.ca.gov.
Patient specific factors such as co-morbidities, co-medications, previous history and risk/benefit assessment should be considered when making drug selection. Not all pain conditions are responsive to opioid therapy. If adequate pain control or improved functioning are not achieved despite opioid dose titration, reassess treatment strategy and consider maintaining non-opioid options.

Non-Opioid Therapies should be tried, optimized, and their effectiveness well documented in the patient’s chart BEFORE Opioid Therapy is considered (Refer to Pain Management Part 2—Therapy—Non-Opioid Care Guide) [CDC Recommendation #1]

- Self-management education is a critical component of non-opioid therapies that should continue when/if opioids are prescribed.
- The goal of opioid therapy for chronic pain is reduction of pain to improve function, typically 20-30% reduction.
- Pain management/coping strategies should be encouraged to continue to be practiced as well (i.e., avoiding negative self talk, finding distractions, meditation, and visualization).
- The patient education materials included in this care guide provide interactive tools to assist the provider in communicating with their patients and actively engaging patients to participate in their own care.
- Visit Preparation: Patients should be encouraged to continue preparing for each visit by filling out the PE-2 and PE-3 forms, Chronic Pain: Preparing for Your Health Care Visit before each visit.

Prescribe immediate release (IR) opioids when initiating opioid therapy

- CDC guidelines [CDC Recommendation #4] recommend prescribing IR over extended release/long-acting (ER/LA) opioid as a first-line therapy. ER/LA opioids may only be appropriate for opioid tolerant patients.
- IR opioid agents on formulary include: Tylenol with codeine, and morphine.
- New orders for controlled medication for an opioid naïve patient—defined as those who have not received opioids in the 30 days prior to the acute event or surgery—are limited to a maximum duration of 7 days and require reassessment prior to continuation (see table on page 9).
- Use opioids in conjunction with acetaminophen, NSAIDS, and/or adjuvants according to pain type and contributing comorbidities for their opioid sparing effects.
- A lack of response to the addition of an opioid despite dose escalation may indicate opioid non-responsive pain and opioid therapy should be discontinued.

Limit daily dosage to less than 50 MME and avoid or justify dosages greater than 90 MME

- Given dose-dependent risks, the lowest effective dose should be utilized. To achieve this, start with a low dose and slowly titrate. In general, titration should not occur more frequently than every 5 half lives.
- Persistent pain is not necessarily an indication to increase opioid dose.
- Additional risk-benefit reassessment needs to occur when increasing dosages over 50 MME. The CDC advises clinicians to avoid prescribing, or otherwise carefully justify, daily dosages over 90 MME. If prescribing ≥ 50 MME/day, increase follow-up frequency [CDC Recommendation #5]

For acute pain, limit duration of opioid therapy to 3-7 days

- The typical duration of treatment needed for acute pain is based on a number of guidelines from emergency rooms and other acute care settings. The CDC recommends 3-7 days as sufficient for most acute pain seen by primary care clinicians [CDC Recommendation #6].

Evaluating benefits and harms frequently

- Initial opioid therapy will need to be evaluated within the first week of starting opioid therapy. If opioids are continued beyond 7 days, the CDC recommends evaluation of benefits and harm within 1-4 weeks with new therapy and up to a maximum of 12 weeks or more frequently for stable therapy. Whenever harm exceeds potential benefit, discontinuing opioid therapy is advised [CDC Recommendation #7].

Transition to long-acting opioids

- Changing to a long-acting/extended release preparation may be considered when opioids are indicated for chronic pain and therapy is anticipated for greater than 3-4 weeks. Long acting agents available on formulary include: Morphine ER or Methadone. These agents should never be used as first line selections.

Prescribing opioids at time of parole/release

- Patients on chronic opioid therapy will need to be provided with a prescription (written on an approved California Security Prescription Form or electronically if 2-factor authentication is available) for a 30-day supply of their opioid medication in order to facilitate uninterrupted therapy and smooth transition of care when leaving the prison setting. The PCP must consult CURES when a parole/release prescription is written since the prescription will be dispensed to the patient and reported to CURES. Because this is continuation of therapy, this is not restricted to a 7-day duration, a 30-day supply is allowed.
- Provision of naloxone is also required if the daily opioid dosing is ≥ 90 MME (though may be considered for any opioid dose), there is concomitant prescription of sedatives (e.g. benzodiazepines), or an increased risk of overdose including patients with a history of overdose, substance use disorder, or at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant. Provision of naloxone should also be accompanied by education on its use and on overdose prevention.
### Dose Adjustment/Changing Opioid Agent

**Dose Adjustment**
- Dose adjustments may be necessary, but generally not recommended until steady state is reached for the current dose (i.e., after a duration of at least 5 half-lives of the agent being adjusted).
- Additional risk-benefit reassessment needs to occur when increasing dosages over 50 MME.
- The CDC advises clinicians to avoid prescribing, or otherwise carefully justify, daily dosages over 90 MME. If prescribing ≥ 50 MME/day, increase follow-up frequency. [CDC Recommendation #5] (See page 10 for MME calculation).

**Changing Opioid Agent**
Occasionally, due to adverse effects or other compelling reasons, it is necessary to consider an alternate opioid agent. When this occurs, it is important to be able to calculate equianalgesic dosing using a standard equianalgesic table.
- Equianalgesic conversions should not be considered a simple straightforward calculation.
- Significant inter/intra patient variability exists depending on the selected opiate, dosage level, and expected response.
- For most conversions to a different opioid, a reduction of 25-30% of the total daily dose of the new agent is recommended because of incomplete cross-tolerance*.

1. Start with calculating the total 24 hour dose of patient’s current opioid regimen (scheduled & any PRN).
2. Locate the new opioid on the equivalence chart and note the Equianalgesic dose value.
3. Input relevant values into proportion calculation and solve for X:

   **Calculate the new Opioid 24 hour dose**

   \[
   \text{Total mg NEW opioid / 24 hours (X)} = \frac{\text{Total mg of CURRENT opioid / 24 hours}}{\text{Equianalgesic dose of NEW opioid from chart}} \times \frac{\text{Equianalgesic dose of CURRENT opioid from chart}}{\text{Equianalgesic dose of NEW opioid from chart}}
   \]

4. Reduce the calculated dose of the new opioid by 25-30% for incomplete cross tolerance*.

### Equianalgesic Opioid Conversion Ratios (Oral)

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Equianalgesic Dose (mg)</th>
<th>Duration</th>
<th>Recommended Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30</td>
<td>3-4 hours</td>
<td>4-6 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20</td>
<td>3-4 hours</td>
<td>4-6 hours</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>6</td>
<td>3-4 hours</td>
<td>4-6 hours</td>
</tr>
<tr>
<td>Codeine</td>
<td>200</td>
<td>3-4 hours</td>
<td>4-6 hours</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30</td>
<td>3-4 hours</td>
<td>4-6 hours</td>
</tr>
</tbody>
</table>

*Incomplete cross-tolerance relates to tolerance to a currently administered opiate that does not extend completely to other opioids.

- This will tend to lower the required dose of the 2nd opioid. Incomplete cross-tolerance exists between all the opioids and the estimated difference between any two opiates could vary widely. This points out the inherent dangers of using an equianalgesic table and the importance of viewing the tabulated data as approximations.
- Recommendations for reduction of the dose of the new opiate by 25 to 30 percent are to account for incomplete cross-tolerance. The new regimen can then be re-titrated to patient response.
- In all cases, repeated comprehensive assessments are necessary in order to successfully manage pain while minimizing side-effects and/or opioid-related harm.
USING METHADONE

- Methadone has been associated with significantly more overdose deaths than any other opioid medication and:
  1. Is not a drug of first choice.
  2. Requires additional vigilance with authorization.
- It is critical to understand the pharmacokinetics of methadone when converting patients from other opioids. For additional prescribing information, refer to www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm.
- Duration of analgesia is approximately 3-6 hours extending to 6-24 hours with repeated dosing. However, due to its long half-life (8-59 hours), methadone plasma levels may take about 7 days to stabilize. Therefore, avoid any increase in dose more frequently than every 7 days.
- Any indication of overmedication during the 3-8 hour post-dose period is a basis for immediate dose reduction. In fact, markedly improved analgesia reported within the first few days may be an indication for dose reduction since the plasma level will continue to climb until peaking at 7 days.
- Death by accumulated toxicity may result from overaggressive titration. During initial dosing, patients need to be followed closely. Ideal analgesic effect with methadone is achieved with dosing intervals 3-4 times daily.
- Deaths due to cardiac and respiratory complications have been reported during initiation and conversion to methadone. Due to potential cardiac conduction effects, it is imperative to obtain ECG at baseline, at one month, and annually as an additional part of routine monitoring for patients on methadone.
- Any sign of significant QT interval prolongation while on methadone—increasing the risk for serious arrhythmia and Torsades de pointe—is an indication to discontinue methadone.

CONVERSION TO METHADONE

- Conversions to, and initiating therapy with methadone, can be very challenging because of the complex pharmacology of this agent.
- The conversion between methadone and another opioid are NOT bi-directional. Note that the conversion ratio for methadone changes depending on the calculated morphine equivalents.

<table>
<thead>
<tr>
<th>Morphine Equivalents</th>
<th>30-90 mg/day</th>
<th>90-300 mg/day</th>
<th>300-500 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine : Methadone</td>
<td>4 : 1</td>
<td>8 : 1</td>
<td>12 : 1</td>
</tr>
</tbody>
</table>

Example equivalent dose conversion
- MORPHINE 60 mg = METHADONE 15 mg
- MORPHINE 240 mg = METHADONE 30 mg
- MORPHINE 480 mg = METHADONE 40 mg

- When converting a patient who was previously receiving chronic doses of methadone to another opiate, the conversion factor must be adjusted upward in order to reduce the calculated equianalgesic dosage of the new opioid.
- Currently, there is a lack of consensus regarding an accepted conversion ratio for substituting methadone with another opioid. Consider consultation with a pain specialist or other practitioner with experience using methadone for chronic pain if such need for conversion arises.
- It is generally best to use a more conservative estimate and re-titrate as needed in order to assure patient safety.

SUMMARY OF CONTROLLED MEDICATION ORDER DURATIONS

<table>
<thead>
<tr>
<th>New or Stable</th>
<th>DEA Schedule</th>
<th>Maximum Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>II - V</td>
<td>7 days</td>
</tr>
<tr>
<td>Stable</td>
<td>II</td>
<td>30 days (except Hospice/ Palliative Care allows up to 60 days)</td>
</tr>
<tr>
<td>Stable</td>
<td>III - V</td>
<td>90 days</td>
</tr>
</tbody>
</table>
March 2019

CCHCS Care Guide: Pain Management Part 3—Opioid Therapy

CALCULATING THE TOTAL DAILY DOSE OF OPIOIDS

Calculating Morphine Milligram Equivalents (MME)
1. Determine the total daily amount of each opioid the patient takes.
2. Convert each to MMEs – multiply the dose for each opioid by the conversion factor (see table at right).
3. Add them together.

Caution: Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another – the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics.

Use Extra Caution:
• Methadone: the conversion factor increases at higher doses

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

<table>
<thead>
<tr>
<th>OPIOID</th>
<th>CONVERSION FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine (doses in mg/day except where noted)</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>5</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
</tr>
<tr>
<td>1-20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21-40 mg/day</td>
<td>8</td>
</tr>
<tr>
<td>≥ 41-80 mg/day</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
</tr>
</tbody>
</table>

TAPERING/DISCONTINUING OPIOIDS

Setting clear expectations at the onset of therapy regarding plans to taper and discontinue is highly recommended. Opioid therapy for chronic non-malignant pain should never be considered a long-term solution. Therefore, there should always be some expectation for eventual discontinuation of opioid therapy.

When to Taper or Discontinue Opioid Therapy:
• Patient requests opioid taper.
• Patient shows no sustained clinically meaningful improvement in function.
• Suspect Opioid-Induced Hyperalgesia if opioid therapy effect wanes in absence of disease progression, in the context of unexplained pain reports or diffuse hypersensitivity unassociated with the original pain, and/or increased pain with increasing opioid dosage.
• Patient’s risk from continued treatment outweighs the benefit (e.g., decreased function and increased risk for opioid-related toxicity from concurrent drug therapy or comorbid medical conditions).
• Adverse effects evident, such as over-sedation, overdose, or development of addiction.
• Patient has evident SUD – list in problem list in the health record and consider role of Medication Assisted Therapy.
• Use of opioids is not in compliance with the Opioid Informed Consent (CDCR 7474) such as:
  • Repeated no show for appointments.
  • The patient is belligerent towards clinical staff.
  • Evident use of illicit drugs (opioids are to be discontinued rather than tapered).
• Patient exhibits aberrant behaviors.
• In general, tapering opioid medication is done to minimize the symptoms of opioid withdrawal that may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors.
  • In order to minimize symptoms of opioid withdrawal, tapers should proceed at 10-15% of the starting dose each week.
  • Tapers are generally better tolerated at higher doses (at the beginning of a taper) than at the lower doses. Therefore tapers may have to be slower toward the end of a taper.
• 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 (OUD).
• 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.
• There may be apprehension about worsening of pain, withdrawal symptoms, or access to pain management. Mitigating these concerns proactively is useful to maintaining a productive therapeutic relationship and garnering support for future therapeutic trials.
MONITORING

Opioid therapy requires careful monitoring. Follow-up assessments should be scheduled according to these general guidelines:

**How Often to Evaluate**
- For the first 3-6 months after initiating opioid therapy, follow-up weekly during initial titration (and any subsequent dosage change) and every 2-4 weeks thereafter.
- If dose is ≥ 90 MME, or other concern for high risk, reassess at least monthly (ongoing).
- After 6 months, and if dose is ≤ 90 MME, may reassess at intervals of every 6-12 weeks if remains stable and without aberrant behavior at provider discretion.
- Follow-up interval should never exceed 12 weeks.

**What to Assess**
- At each follow-up, *at the very least*, assess The 4 A’s:
  - Analgesia
  - ADLs (function)
  - Adverse effects
  - Aberrant behaviors
- Assure that there is clinically meaningful improvement while on opioids (at least 20-30% improvement in pain and function without significant risk or harm).
- The patient demonstrates ability to understand and follow rules outlined in the opioid therapy informed consent (may be contraindicated in patients with multiple rule violation reports [RVR]).
- DDP patients may need additional support with instruction, demonstrating understanding, and with medication dispensing (i.e., at pill line).
- Discuss known risks, realistic benefits, and potential harm periodically with patient [CDC Recommendation #7]
- Consider if the patient is at risk for victimization (due to access to opioids).
- Evaluate the patient’s ability and willingness to engage in a therapeutic relationship recognizing the need and expectations for ongoing assessment and follow-up.
- Assess for OUD, SUD, overdose potential, and suicidality, as risks and benefits can change over time.
- Provide ongoing patient education regarding potential opioid side effects, overdose education, etc.
- Re-examine the rationale for continuing the patient on opioid therapy.
- UDT– frequency based on risk category below [CDC Recommendation #10].

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Characteristics</strong></td>
<td>No history of SUD</td>
<td>History of non-opioid SUD</td>
<td>Active SUD</td>
</tr>
<tr>
<td></td>
<td>Minimal risk factors</td>
<td>History of Injection-related disease</td>
<td>Significant risk factors</td>
</tr>
<tr>
<td></td>
<td>- no family hx of SUD</td>
<td>(HCV, HIV)</td>
<td>- family hx of SUD</td>
</tr>
<tr>
<td></td>
<td>- no psych hx</td>
<td>Significant risk factors</td>
<td>- psychiatric hx</td>
</tr>
<tr>
<td><strong>UDT frequency</strong></td>
<td>Baseline + q 3-6 months</td>
<td>Baseline + q 2-3 months</td>
<td>Baseline + monthly</td>
</tr>
</tbody>
</table>

**Know How Opioids Metabolize**
When interpreting the results of a UDT it is important to know how opioids metabolize so that if you can determine whether the identified substance is an expected metabolite of the prescribed medication, or represents an unexpected drug which was not prescribed to the patient.
In general, UDT is used to gain an understanding of the patient's medication-taking behaviors, potential aberrant behaviors, and to identify the risk of drug–drug interactions that may produce serious health risks.

Essential to monitoring a patient on opioid therapy, a UDT result that is expectedly positive for a prescribed medication suggests medication adherence, and an unexpected result (e.g., negative for prescribed medication, or positive for non-prescribed medication or illicit substance) suggests either nonadherence to the prescribed regimen or aberrant behaviors that should be further explored.

It is important to understand:
1) Medications prescribed and relevant metabolites.
2) Analytical cutoffs.
3) Opioid analgesic metabolism (Reference the figure on the bottom of page 11).
4) Interpretation of quantitative values.
5) Monitoring concomitant alcohol use, and
6) Testing frequency (based on risk category, see previous page).

Urine Drug Testing (UDT) Monitoring Algorithm

- Obtain Random Urine Sample
  - Temp 90°F-100°F
  - Vol ≥ 30 mL

- UDT is consistent with therapy (see metabolic pathway on page 11)

- Any ILLICIT agents?
  + Cocaine
  + Amphetamines
  + Heroin
  + Alcohol
  + Cannabis

- Discuss unexpected result with patient

- STOP
  - Patient not eligible for opioid therapy
  - See Pain Management – Therapy (Non-Opioid) Care Guide

- Does patient acknowledge use?

- Refer to SUD Treatment if interested

- Negative for prescribed drugs

- Suspected Abuse/Diversion?

- Consider altering treatment

- Increase UDT frequency
### Interpreting Unexpected UDT Results

<table>
<thead>
<tr>
<th>Observation</th>
<th>Possible Interpretation</th>
<th>Possible Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed drug not observed</td>
<td>Patient non-adherent (e.g., diversion, unwilling/unable to go to pill-line for doses, significant period of time since last dose)</td>
<td>Consultation with patient to determine underlying cause, changes in treatment regimen based on additional information.</td>
</tr>
<tr>
<td>Non-prescribed drug observed</td>
<td>Previously unidentified or unknown prescribed medication, medication obtained from friend/family, attempt to self-medicate symptoms</td>
<td>Consultation, possible referral to addiction specialist</td>
</tr>
<tr>
<td>Illicit drug observed</td>
<td>Illicit drug use, addiction</td>
<td>Consider referral to addiction specialist</td>
</tr>
<tr>
<td>Low creatinine, specific gravity</td>
<td>Over hydration, low body mass, attempt at deception by dilution, renal tubular dysfunction</td>
<td>Consultation with patient. Review medical and physical history</td>
</tr>
<tr>
<td>Parent drug only, no metabolite</td>
<td>Timing of dose (recent ingestion of parent medication without time for metabolism); metabolic variability (e.g., P450 2D6 deficient and unable to metabolize parent medication); attempt at deception</td>
<td>Consultation with patient. Review medication and dose taking history; consider oral or blood level to assure ingestion</td>
</tr>
<tr>
<td>Very high drug concentration</td>
<td>Metabolic variability (unable to metabolize parent drug; unsanctioned dose increases, opiate abuse)</td>
<td>Consultation with patient. Review of medication records, consider possible aberrant use</td>
</tr>
<tr>
<td>Low concentrations of unexpected drugs and/or metabolites</td>
<td>Remote use of unexpected substance/drug. Note: Expected with benzodiazepines and methadone with long half-lives of weeks</td>
<td>Monitor using creatinine corrected values, which should decline over time</td>
</tr>
</tbody>
</table>


### TREATING OPIOID OVERDOSE

Classic signs of overdose: pinpoint pupils, slow and shallow breathing, unconsciousness and/or unresponsiveness. Be mindful that opioid overdose can result from ingestion of prescription and/or illicit drugs and timely response to a patient found down is necessary to reverse this potentially fatal circumstance.

**Action steps:**

1. **Activate emergency response**
2. **Restore adequate ventilation and oxygenation**
   - Open airway with chin-lift and jaw-thrust maneuvers. Use bag-valve mask ventilation.
3. **Administer naloxone**
   - Open nasal spray by peeling back tab with the circle.
   - Hold with your thumb on the bottom of the plunger and first and middle fingers on either side of the nozzle.
   - With the person's head tilted back, insert tip of nozzle into nostril and press the plunger firmly to administer spray.
4. **If no pulse, begin CPR**
   - If incomplete response in consciousness or breathing, repeated naloxone dosing at 2-3 minute intervals may continue during resuscitative efforts until transfer to higher level of care or hospital setting where changing to an IV and/or continuous infusion can be arranged. Also consider other causes for cardiopulmonary collapse. Naloxone time to onset is less than 2 minutes, and duration of action ranges from 20-90 minutes.
5. **Monitor and transfer to higher level of care**
   - Even with successful reversal, transfer to a hospital for close monitoring should be accomplished as soon as feasible.
### MEDICATIONS: OPIOID ANALGESICS

**Boxed Warning** for all analgesics: serious, life-threatening, or fatal respiratory depression

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSING</th>
<th>ADVERSE EFFECTS* / INTERACTIONS</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Acetaminophen/ codeine              | Initial: 30 mg codeine every 4-6 hours PRN                              | • Adverse effects: drowsiness, lightheadedness, dizziness, sedation, nausea and vomiting, constipation, respiratory depression | • Boxed warning: Hepatotoxicity—Do not exceed 4 g/day of acetaminophen  
• Use with caution in elderly, patients with head injury or increased intracranial pressure, impaired renal or hepatic function, GI or GU obstruction, asthma  
• Maximum recommended dose for patients with liver injury from hepatitis C is 2 gm/day. Avoid in patients with significant liver disease or risk of hepatotoxicity  
• Use of codeine is contraindicated in patients who are receiving or who have received MAOI therapy within past 14 days. |
| (Tylenol w/ Codeine®)               | Titration: Increase dose as needed and tolerated up to MAX 30-60 mg codeine every 4 hours PRN |                                                                                               |                                                                                                                                                                                                         |
| Tablet (Tylenol #3): 30mg/300mg     | Maximum single dose of codeine is 60 mg/dose. Maximum dose of acetaminophen is 4 g/day |                                                                                               |                                                                                                                                                                                                         |
| Elixir: 12mg/120mg/5 ml             |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| DOT/NA Mandatory crush & float      |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| Tramadol                            | Initial: If rapid analgesic not required, initiate with 25 mg once daily and titrate 25 mg every 3 days, 100 mg (25 mg QID) Increase by 50 mg every 3 days to 200 mg/day (50 mg QID). After titration, 50-100 mg every 4-6 hours prn If rapid analgesic effect required, 50-100 mg every 4-6 hours prn Renal impairment (CrCl < 30 ml/min): Increase dosage interval to 12 hours; MAX 200 mg/day Liver cirrhosis: 50 mg every 12 hours | • Adverse effects: dizziness, GI upset, constipation, headache, somnolence, pruritis, CNS stimulation, asthenia, sweating, dry mouth, seizures  
• Drug interactions: MAOIs, carbamazepine, SSRIs, SNRIs, TCAs, promethazine, opioids, quinidine, digoxin, warfarin, ketoconazole, erythromycin, rifampin | • Contraindications: Hypercapnia, acute or severe bronchial asthma, or significant respiratory depression; hypersensitivity to opioids  
• Avoid use in patients who are suicidal or addiction prone  
• Use with caution in elderly, patients with chronic respiratory disorders, seizure disorder, increased intracranial pressure or head injury, liver disease, or renal dysfunction  
• Less constipating than other opioids  
• Slower initiation and titration improves tolerability  
• Use of tramadol is contraindicated in patients who have received MAOI therapy within past 14 days |
| (Ultram®)                           |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| Immediate-release tablets: 50 mg    |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| $$$                                 |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| DOT/NA Mandatory crush & float      |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| Morphine (MSIR®, MS Contin®)        | Initial dose:  
IR: 15 mg every 4 hours as needed  
SR: Patients previously on codeine/hydrocodone products or opioid naive: 15 mg SR every 12 hours  
Opioid tolerant patients: 15 mg SR every 8-12 hours  
Titration: Increase by 15 mg every 3-7 days  
Renal impairment: use lower initial doses and titrate slowly  
Hepatic impairment: use lower initial doses and titrate slowly OR increase dosing interval by 1.5-2 times normal interval | • Adverse effects: nausea, vomiting, constipation, dizziness, sedation, respiratory depression, urinary retention  
• Drug interactions (significant): barbiturates, gabapentin, benzodiazepines, chlorpromazine, MAOIs, rifampin, TCAs, cimetidine, cyclosporine, opioid agonists/antagonists (e.g., tramadol) | • Boxed warning: Life-threatening respiratory depression—monitor for respiratory depression during initiation or following a dose increase  
• Contraindications: significant respiratory disorder, acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, paralytic ileus  
• Use caution in patients with head injury, intracranial pressure, severe renal or hepatic insufficiency, seizure disorders, bleeding diathesis, elderly, pregnancy, with concomitant use CNS depressants  
• Do not use SR formulation as PRN analgesic  
• Use of morphine is contraindicated in patients who have received MAOI therapy within past 14 days  
• IV dose: 0.1-0.2 mg/kg every 4 hours prn |
| IR: 15mg, 30mg tab SR:15mg, 30mg, 60mg tab |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| Soln: 10 mg/5 ml                    |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| Inj: 10mg/ml vial                   |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| DOT/NAT only Cannot crush SR        |                                                                        |                                                                                               |                                                                                                                                                                                                         |
| $$$                                 |                                                                        |                                                                                               |                                                                                                                                                                                                         |

**Bold=formulary**  *See prescribing information for complete description of doses, adverse effects, and drug interactions.*
## Opioid Analgesics Continued

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Adverse Effects* / Interactions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>Initial dose: 2.5 mg to 5 mg QHS for patients who are not opioid naive</td>
<td>• Adverse effects: nausea, vomiting, constipation, dizziness, sedation, sweating, QT prolongation/ sudden death, respiratory depression, seizures, hypotension</td>
<td>Statements from the FDA regarding methadone: Prescribers of methadone should be familiar with methadone’s toxicities and unique pharmacologic properties. Methadone doses for pain should be carefully selected and slowly titrated to analgesic effect even in patients who are opioid-tolerant. Physicians should closely monitor patients when converting them from other opioids and changing the methadone dose, and thoroughly instruct patients how to take methadone.</td>
</tr>
<tr>
<td>Tablet: 5mg, 10mg</td>
<td>Elderly: 1 mg QD to BID</td>
<td>• Drug Interactions: Azole antifungals, antiarrhythmics, benzodiazepines, antipsychotics, cinemidine, cyclobenzaprine, macrolides, fluoroquinolones, SSRIs, TCAs, pentamidine, many HIV Meds, rifampin, carbamazepine, risperidone, phenobarbital, phenytoin</td>
<td>• Boxed warning: Life-threatening respiratory depression—monitor for respiratory depression especially during initiation or following dose increases; Life-threatening QT prolongation—closely monitor patients for changes in cardiac rhythm during initiation and titration</td>
</tr>
<tr>
<td>Soln: 10mg/ml</td>
<td>Max effect: 7-10 days</td>
<td></td>
<td>Methadone use is associated with more frequent deaths than other opioids</td>
</tr>
<tr>
<td>DOT/NA only</td>
<td>Renal impairment: lower initial dose, longer dosing intervals, slower dose titration recommended</td>
<td></td>
<td>Should not be used as PRN supplemental opioid therapy</td>
</tr>
<tr>
<td>crush &amp; float</td>
<td>Renal impairment: lower initial dose, longer dosing intervals, slower dose titration recommended</td>
<td></td>
<td>Contraindications: significant respiratory disorder, acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, paralytic ileus</td>
</tr>
<tr>
<td>$</td>
<td>Hepatic impairment: lower initial doses and slower dose titration recommended</td>
<td></td>
<td>Obtain ECG at baseline, 1 month &amp; annually due to QT prolongation. (Increase ECG monitoring if patient receiving &gt;100 mg/day or if unexplained syncope or seizure occurs while on methadone):</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt; If QTc is &gt;450 ms but &lt;500 ms; consider risk vs. benefit-monitor more frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt; If QTc is &gt;500 ms consider alternative therapy, dose reduction, or elimination of contributing factors (e.g., other medications)</td>
</tr>
</tbody>
</table>

**Methadone’s elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours).** Methadone’s peak respiratory depressant effects typically occur later and persist longer than its peak analgesic effects. During treatment initiation, methadone’s full analgesic effect is usually not attained until 3-5 days of dosing. Initiation and titration to analgesic effect and dose adjustments should be done cautiously and in consideration of these properties. In chronic use, methadone may be retained in the liver and then slowly released, prolonging the duration of action despite low plasma concentrations.

**Cross-tolerance between methadone and other opioids is incomplete.** This incomplete cross-tolerance makes the conversion of patients on other opioids to methadone complex and does not eliminate the possibility of methadone overdose, even in patients tolerant to other opioids. Deaths have been reported during conversion from chronic, high-dose treatment with other opioid agonists to methadone. It is critical to understand the pharmacokinetics of methadone when converting patients from other opioids to methadone. Particular vigilance is necessary during treatment initiation, during conversion from one opioid to another, and during dose adjustments.

**Bold=formulary**

*See prescribing information for complete description of doses, adverse effects, and drug interactions.*
OPIOIDS FOR CHRONIC PAIN: WHAT YOU SHOULD KNOW

WHAT ARE OPIOIDS?
Opioids are a family of pain-relieving medications. They may also be called opiates, narcotics, or strong pain relievers. Because they are strong medicines, they should be taken cautiously.

If taken too long, they can cause your pain to get worse, and you could get addicted to them.

When taken in low doses, they are safe and effective. They can be deadly if not taken as directed.

IMPORTANT THINGS TO REMEMBER
- Take your medication exactly as prescribed.
- Tell your medical provider all the prescription and over the counter medicines you take.
- Do NOT drink alcohol, use illegal drugs, or take sleep aids or muscle relaxants with opioids.
- Never take medications that are not prescribed to you.

POTENTIAL SIDE EFFECTS
- Fatigue
- Nausea/Vomiting
- Depression
- Anxiety
- Chronic Constipation
- Sleep Problems
- Breathing problems
- Itching
- Dry mouth
- Confusion
- Dizziness, falls
- Irregular heart beat
- Addiction
- Dependence
- Sexual dysfunction
- Withdrawal symptoms: restlessness, irritability, muscle and bone pain

Discuss all side effects and concerns with your medical provider.

URINE SCREEN DRUG TEST
You may be asked to give a urine sample at any time. Failure to comply will result in medications not given.

It is important to stick to your treatment plan and the pain agreement you have set up with your medical provider.
Many things can affect your pain. These can include:

- Stress
- Poor Sleep
- Depression
- Anger
- Feeling alone
- Sadness
- Fear
- Being worried/anxious

When you visit with your Health Care Team, be ready to talk about:
1. What do you think is wrong?
2. Any new symptoms or improvements since your last visit?
3. How is the pain affecting your daily life?
4. Any other questions?

Before your visit, look at each section below and circle the number that most closely matches how you have felt in that area over the last 2-3 weeks.

### Pain Level

- **No Pain**: 1, 2, 3, 4, 5, 6, 7, 8, 9, **Worst Pain**: 9, 10

### Stress

- **No Stress**: 1, 2, 3, 4, 5, 6, 7, 8, **Very Stressed**: 9, 10

### Sleep

- **Fully Rested**: 1, 2, 3, 4, 5, 6, 7, 8, **Not Sleeping Well**: 9, 10

CHRONIC PAIN: PREPARING FOR YOUR HEALTH CARE VISIT PART 2

Look at each section below and circle the number that most closely matches how you have felt in that area over the last 2-3 weeks.

### Fear of Pain

<table>
<thead>
<tr>
<th>No Fear</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Very Afraid</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

### Hunger

<table>
<thead>
<tr>
<th>Eating Normal Meals</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Not Hungry</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

### Mood

<table>
<thead>
<tr>
<th>Happy &amp; Calm</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>Sad, Depressed, or Anxious</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

### Activity

<table>
<thead>
<tr>
<th>Normal Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>No Activity</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

### Using Medications as Prescribed

<table>
<thead>
<tr>
<th>Always Take As Directed</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Do Not Take As Directed</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

---

OPIÁCEOS PARA EL DOLOR CRÓNICO: LO QUE DEBE SABER

¿QUÉ SON LOS OPIÁCEOS?
Los opiáceos son una familia de medicamentos que alivian el dolor. También se conocen como opiatos, narcóticos o analgésicos fuertes. Como son medicamentos fuertes, deben tomarse con precaución.

Si se toman durante mucho tiempo, pueden provocar que empeore su dolor y podría volverse adicto a ellos.

Cuando se toman en dosis bajas, son seguros y eficaces. Pueden ser mortales si no se toman según las indicaciones.

COSAS IMPORTANTES QUE DEBE RECORDAR
- Tome sus medicamentos exactamente como se le indicó.
- Informe a su proveedor médico todos los medicamentos que toma, con y sin receta médica.
- NO consuma alcohol, drogas ilegales, pastillas para dormir ni relajantes musculares con opiáceos.
- Nunca tome medicamentos que no le recetaron.

POSIBLES EFECTOS SECUNDARIOS
- Fatiga
- Náuseas o vómito
- Depresión
- Ansiedad
- Estreñimiento crónico
- Problemas de sueño
- Problemas para respirar
- Comezón
- Boca seca
- Confusión
- Mareo, caídas
- Ritmo cardiaco irregular
- Adicción
- Dependencia
- Disfunción sexual
- Síntomas de la abstinencia: agitación, irritabilidad, dolor muscular y óseo

Dígale a su proveedor médico todos los efectos secundarios e inquietudes que tenga.

EXAMEN DE ORINA PARA DETECTAR EL USO DE DROGAS
Es posible que le soliciten que proporcione una muestra de orina en cualquier momento. Si no la proporciona, no se le darán medicamentos.

Es importante que siga su plan de tratamiento y el acuerdo de dolor que ha establecido con su proveedor médico sobre el dolor.
Muchas cosas pueden afectar su dolor, por ejemplo:

- Estrés
- Falta de sueño
- Depresión
- Enojo
- Sentirse solo
- Tristeza
- Miedo
- Preocupación o ansiedad

Cuando visite a su equipo de atención médica, esté preparado para hablar sobre:

1. ¿Qué considera que está mal?
2. ¿Si tiene algún síntoma nuevo o mejoría desde su última consulta?
3. ¿Cómo afecta su vida diaria el dolor?
4. ¿Otras preguntas que tenga?

Antes de su consulta, revise cada una de las siguientes secciones y marque con un círculo el número que más se acerque a cómo se ha sentido sobre ese tema en las últimas 2 o 3 semanas.

### Nivel de dolor

<table>
<thead>
<tr>
<th>Sin Dolor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Máximo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

### Estrés

<table>
<thead>
<tr>
<th>Sin estrés</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Muy estresado</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

### Sueño

<table>
<thead>
<tr>
<th>Bien descansado</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Difficultad para dormir</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

Revise cada una de las siguientes secciones y marque con un círculo el número que más se acerque a cómo se ha sentido sobre ese tema en las últimas 2 o 3 semanas.

### Miedo de sentir dolor

Sin miedo
1 2 3 4 5 6 7 8 Mucho miedo
9 10

### Hambre

Come alimentos normales
1 2 3 4 5 6 7 8 Sin hambre
9 10

### Estado de ánimo

Contento y tranquilo
1 2 3 4 5 6 7 Triste, deprimido, o ansioso
8 9 10

### Actividad

Actividad normal
1 2 3 4 5 6 7 8 Sin actividad
9 10

### Uso de los medicamentos según lo prescrito

Siempre los toma según lo indicado
1 2 3 4 5 6 7 No los toma según lo indicado
8 9 10
## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

(Patient Completes)

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
*(Circle the number to indicate your answer)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add columns: _____ + _____ + _____ + _____  
= Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

NIDA Quick Screen V1.0

(Provider Completes)

Name: ________________________________ Sex: ( ) F ( ) M Age: _______________

Interviewer: __________________________ Date: ____/____/____

Introduction (Please read to patient)

Hi, I’m __________, nice to meet you. If it’s okay with you, I’d like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we’ll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I’ll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

If the patient says “NO” for all drugs in the Quick Screen, reinforce abstinence. Screening is complete.

If the patient says “YES” to any drugs on the Quick Screen, refer to MAT Care Guide.

More in depth screening may also be done using the NIDA Modified Assist Tool.

This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism’s screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm).
NIDA Modified Assist
(Provider Completes)

Please answer the following questions:

1. In your LIFETIME, which of the following substances have you ever used? (Yes/No)

<table>
<thead>
<tr>
<th>Substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Hallucinogens</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Street opioids</td>
</tr>
<tr>
<td>Prescription stimulants</td>
</tr>
<tr>
<td>Sedatives or sleeping pills</td>
</tr>
<tr>
<td>Prescription opioids</td>
</tr>
</tbody>
</table>

2. In the past 3 months, how often have you used the following substances? (Never, once or twice, monthly, weekly, almost daily)

3. In the past three months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)? (Never, once or twice, monthly, weekly, almost daily)

4. During the past three months, how often has your use of (first drug, second drug, etc.) led to health, social, legal or financial problems? (Never, once or twice, monthly, weekly, almost daily)

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of this substance? (Never, once or twice, monthly, weekly, almost daily)

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)? (Never; yes, but not in the past 3 months; yes, in the past 3 months)

7. Have you ever tried and failed to control, cut down, or stop using this substance? (Never; yes, but not in the past 3 months; yes, in the past 3 months)

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)? (Never; yes, but not in the past 3 months; yes, in the past 3 months)

The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/activities/assist/)
Screener and Opioid Assessment for Patients with Pain (SOAPP)  
(Patient Completes)

SOAPP Version 1.0

Name:_____________________________________________    Date:___________________

Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please answer the questions below using the following scale:

0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

1. How often do you have mood swings?   0  1  2  3  4
2. How often do you smoke a cigarette within an hour after you wake?   0  1  2  3  4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?   0  1  2  3  4
4. How often have any of your close friends had a problem with alcohol or drugs?   0  1  2  3  4
5. How often have others suggested that you have a drug or alcohol problem?   0  1  2  3  4
6. How often have you attended an AA or NA meeting?   0  1  2  3  4
7. How often have you taken medication other than the way that it was prescribed?   0  1  2  3  4
8. How often have you been treated for an alcohol or drug problem?   0  1  2  3  4
9. How often have your medications been lost or stolen?   0  1  2  3  4
10. How often have others expressed concern over your use of medication?   0  1  2  3  4
11. How often have you felt a craving for medication?   0  1  2  3  4
12. How often have you been asked to give a urine screen for substance abuse?   0  1  2  3  4
13. How often have you used illegal drugs (marijuana, cocaine, etc.) in the past 5 years?   0  1  2  3  4
14. How often, in your lifetime, have you had legal problems or been arrested?   0  1  2  3  4

Please include any additional information you wish about the above answers. Thank you.

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Clinical Opiate Withdrawal Scale (COWS)  
(Provider Completes)

For each item, circle the number that best describes the patient’s signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to the assessment, the increase pulse rate would not add to the score.

| Patient’s Name: ___________________________ | Date and Time: __________________ |
| Reason for this assessment: ___________________________ |

<table>
<thead>
<tr>
<th>Resting Pulse Rate: _____ beats/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for 1 minute</td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GI Upset: Over last ½ hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no GI symptoms</td>
</tr>
<tr>
<td>1 stomach cramps</td>
</tr>
<tr>
<td>2 nausea or loose stool</td>
</tr>
<tr>
<td>3 vomiting or diarrhea</td>
</tr>
<tr>
<td>5 multiple episodes of diarrhea or vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: Over past ½ hour not accounted for by room temperature or patient activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tremor: Observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>4 gross tremor or muscle twitching</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness: Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yawning: Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pupils pinned or normal size for room light</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety or Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 none</td>
</tr>
<tr>
<td>1 patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 patient obviously irritable or anxious</td>
</tr>
<tr>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint Aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gooseflesh Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>3 piloerrection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>5 prominent piloerrection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny nose or tearing: Not accounted for by cold symptoms or allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2 nose running or tearing</td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Score: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total score is the sum of all 11 items</td>
</tr>
</tbody>
</table>

Initial of person completing assessment: ___________________________ |

Score 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Below are InterQual (IQ) guidelines for cervical, thoracic and lumbar spine imaging

- CT scan can assess osseous structures better than either plain radiography or MRI and is therefore helpful in assessing for bony disease. However, a CT alone is unable to visualize nerve roots, so it is not helpful in the direct imaging of a radicular process. If MRI cannot be done because of metal fragments, etc. use CT Myelogram

- Why not to image early:
  - Abnormal imaging findings often do not correlate with location and type of pain, or clinical severity/improvement.
  - Radiation, unnecessary work-ups, contrast reactions
  - 2009 systematic meta-analysis of 6 trials with MRI and CT in acute and subacute LBP- NO significant differences at 3 months or 6-12 months.

---

### InterQual Cervical, Thoracic and Lumbar Imaging Summary Table

**Obtained from IQ Version 2017.2—Please refer to the most current IQ guidelines**

<table>
<thead>
<tr>
<th>Suspected Disease Entity</th>
<th>Clinical Features and Clues</th>
<th>Study of Choice as per IQ guidelines</th>
</tr>
</thead>
</table>
| **Somatic neck, upper back and lumbar back pain** | • Without neurologic deficits  
• Other causes above ruled out by history and physical examination **AND**  
• Conservative therapy failure:  
  ▶ NSAIDS or Acetaminophen trial ≥ 3 wks  
  ▶ PT or home exercise ≥ 6 wks  
  ▶ Activity modification ≥ 6 wks  
  ▶ Patient Ed: pain management, posture, lifting, self-care | X-Rays  
(Flexion and extension generally not needed) |
| **Cervical, Thoracic or Lumbar disc herniation or foraminal stenosis** | • Acute symptoms without severe or progressive neurologic deficits do not need imaging  
• Unilateral radicular pain with sensory or motor and reflex deficits in a nerve root distribution  
• Pain and weakness most indicative  
• Weakness generally ≤ 3/5 (unable to withstand any resistance, but can withstand gravity or worse)  
• Motor weakness generally indicates more severe compression  
• Worsening (intensified pain or more distal extension) symptoms and/or weakness or motor deficit on clinical re-evaluation  
• Continued severe pain (≥ 8-10/10 after NSAIDs or Acetaminophen ≥ 3 days)  
• Pain ≥ 7/10 on pain scale and at least ≥ 3/10  
• Pain unrelieved by change in body position  
• Pain interferes with function/ADLs **AND**  
• Conservative therapy failure  
  ▶ NSAIDS or Acetaminophen trial ≥ 3 weeks  
  ▶ PT or home exercise ≥ 6 weeks  
  ▶ Activity modification ≥ 6 weeks  
  ▶ Patient Ed: pain management, posture, lifting, self-care  
  ▶ Psychosocial evaluation done  
**OR**  
• Excruciating unremitting symptoms totally unresponsive to treatment and interferes significantly with function (partial relief does not qualify) | MRI without contrast/CT/MYL-CT  
If MRI N/A or not feasible |
| **Cervical Spinal stenosis** | For Cervical Spinal Stenosis:  
• Numbness, weakness, or tingling in hand, arm, foot, or leg  
• Neck pain  
• Symptoms interfere with function/ADLs | MRI without contrast  
CT/MYL-CT  
If MRI N/A or not feasible |
<table>
<thead>
<tr>
<th>Suspected Disease Entity</th>
<th>Clinical Features and Clues</th>
<th>Study of Choice as per IQ guidelines</th>
</tr>
</thead>
</table>
| Thoracic spinal stenosis| For Thoracic Spinal Stenosis:  
- Pain in the ribs and affected area of the back radiating down the back or legs  
- Pain in one or more internal organs  
- Bilateral symptoms- “spinal claudication” in buttocks, thighs, or calves  
- Symptoms worsen with prolonged standing  
- Symptoms interfere with function/ADLs  
For Lumbar Spinal Stenosis:  
- Bilateral symptoms- “spinal claudication” in buttocks, thighs, or calves  
- Pain and/or paresthesias improve with forward flexion/worsen with walking  
- Symptoms worsen with prolonged standing  
- Symptoms interfere with function/ADLs | MRI without contrast  
CT/MYL-CT  
If MRI N/A or not feasible |
| Lumbar spinal stenosis (single or multi-level narrowing of the spinal canal) | Additionally for Cervical, Thoracic and Lumbar Spinal Stenosis: AND  
- Conservative therapy failure:  
  - NSAIDS or Acetaminophen trial ≥ 3 wks  
  - PT or home exercise ≥ 6 wks  
  - Activity modification ≥ 6 wks  
  - Patient Ed: pain management, posture, lifting, self-care  
  - Psychosocial evaluation done  
OR  
- Excruciating unremitting symptoms totally unresponsive to treatment and interfere significantly with function (partial relief does not qualify) | MRI  
MYL-CT  
If MRI N/A or not feasible |
| Cervical Myelopathy/ Cord compression (Urgent) | • Bilateral upper or lower extremity pain, numbness, or weakness  
• Bowel and bladder dysfunction (other etiologies excluded)  
• Spasticity by physical exam (other etiologies excluded)  
• B/L loss of dexterity  
• Unsteady gait (other etiologies excluded) | MRI  
MYL-CT  
If MRI N/A or not feasible |
| Thoracic Myelopathy/ Cord compression | • Bilateral upper or lower extremity pain, numbness, or weakness  
• Bowel and bladder dysfunction (other etiologies excluded)  
• Spasticity by physical exam (other etiologies excluded)  
• Diminished rectal sphincter tone by physical examination (other etiologies excluded) | MRI  
MYL-CT  
(If MRI N/A or not feasible) |
| Cauda equina syndrome | • Bilateral lower extremity weakness, numbness or pain  
• Sensory pattern often diffuse with overlapping nerve roots, asymmetric or unilateral. *Almost never isolated sensory*  
• Perianal or perineal “saddle” anesthesia, ↓ anal sphincter tone  
• Progressive lower spinal stenosis  
• Bowel or bladder dysfunction (retention, frequency, hesitancy, urgency or incontinence) without known etiology – *late ominous* | MRI  
CT/MYL-CT  
(If MRI N/A or not feasible) |
### InterQual Cervical, Thoracic & Lumbar Imaging Summary Table

<table>
<thead>
<tr>
<th>Suspected Disease Entity</th>
<th>Clinical Features and Clues</th>
<th>Study of Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected epidural abscess</td>
<td>• Classic – spinal pain or neurologic deficit with fever and elevated ESR</td>
<td>MRI with gadolinium CT/MYL-CT (If MRI N/A or not feasible)</td>
</tr>
<tr>
<td></td>
<td>• <strong>Risk factor(s)</strong> – IVDA, immunosuppression, recent spinal or epidural procedure, vertebral trauma, diabetes, cancer, ESRD, AIDS, transplant medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Axial/localized spine pain (but symptoms can be nonspecific)</td>
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<tr>
<td></td>
<td>• Pain increases with movement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Temp &gt; 100.4° F (38° C)</td>
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</tr>
<tr>
<td></td>
<td>• Positive blood culture, ↑WBC ↑CRP, ESR &gt;30 mm/hr (Note: Fever and WBC may be misleadingly low in immunosuppressed)</td>
<td></td>
</tr>
<tr>
<td>Spinal tumor</td>
<td>• Known spinal tumor with indication to re-image</td>
<td>MRI with and without gadolinium MYL-CT (If MRI N/A or not feasible)</td>
</tr>
<tr>
<td></td>
<td>• Localized spine pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Palpable mass on the spine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nocturnal pain and unresponsive to rest</td>
<td></td>
</tr>
<tr>
<td>Bony metastases</td>
<td>• History of cancer (most common: primary breast, lung and prostate, renal, thyroid and multiple myeloma)</td>
<td>MRI with and without gadolinium CT/MYL-CT/ Bone scan (If MRI N/A or not feasible)</td>
</tr>
<tr>
<td></td>
<td>• Spine pain over bone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• X-Ray or bone scan bone lesion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Neurologic deficit on exam (nerve root: weakness, paralysis, or paresthesias)</td>
<td></td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>• <strong>Risk factors:</strong> Chronic indwelling catheters (Thoracic/Lumbar), recent (especially orthopedic) surgery, Intravenous Drug Abuse (VDA), open fracture, penetrating trauma, local soft tissue ulceration, immunosuppressed</td>
<td>MRI /CT (If MRI N/A or not feasible)</td>
</tr>
<tr>
<td></td>
<td>• Diagnosed by X-Ray and need further evaluation for treatment decisions (X-Rays often negative in early otitis media)</td>
<td></td>
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<tr>
<td></td>
<td>• Continued symptoms/findings after antibiotics Rx and need evaluation for preoperative/other treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Localized neck pain (cervical) or spine pain (Thoracic/Lumbar), myalgias, swelling, drainage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• T&gt; 100.4° F, + blood culture,↑WBC, ↑ESR &gt; 30 mm/hr, ↑ CRP</td>
<td></td>
</tr>
<tr>
<td>Disc Space Infection</td>
<td>• <strong>Risk Factors:</strong> Advanced age, immunosuppression, recent spinal surgery, vascular access, IVDA</td>
<td>MRI /CT (If MRI N/A or not feasible)</td>
</tr>
<tr>
<td></td>
<td>• Localized spine pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Temperature &gt; 100.4° F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Positive blood culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ESR &gt; 30 mm/hr, ↑WBC ↑CRP</td>
<td></td>
</tr>
</tbody>
</table>
### 2016 CDC Recommendations for Prescribing Opioids for Chronic Pain

#### Determining When to Initiate or Continue Opioids for Chronic Pain

1. Non-pharmacologic therapy and non-opioid 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 non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

2. 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 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.

3. 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.
   - Use Informed Consent for Treatment with Opioid Medication for all patients on chronic opioid therapy.

#### Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of ER/LA opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should:
   - Use caution when prescribing opioids at any dosage.
   - Carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 MME/day.
   - Avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
     - Doses > 50 MME/day require CTEC Approval.

6. 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 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. Clinicians should evaluate benefits and harms with patients:
   - Within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
   - On continued therapy 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.

#### Assessing Risk and Addressing Harms of Opioid Use

8. 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. (Most of our patients have risk factors for opioid related harm. Ensure benefits > risks, use lowest dose possible.)

9. 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. (CURES - California’s prescription monitoring program [https://oag.ca.gov/cures] to check a patient’s history of controlled medications.)

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

12. 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. (Medication Assisted Treatment [MAT] with Naltrexone available at pilot institutions.)

Adapted from Box 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative care, and end-of-life care:
https://cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm#B1_down
I consent to allowing _________________ (my provider) to prescribe opioid medications as part of my chronic pain treatment plan.

I understand that opioid medications have major risks including:

- **Side Effects** such as dizziness, itching, sleepiness, nausea, slowed breathing, constipation, among others.
- **Risk of an Overdose** – especially if used with other medications, alcohol, or illegal drugs. This can cause death by stopping my breathing.
- **Physical Dependence** can develop with continuous use, maybe requiring higher doses. If medication is suddenly stopped, it could lead to withdrawal symptoms (flu like symptoms: nausea, diarrhea, aches, sweats, chills, irritability, tremors, and confusion), which are uncomfortable, but not life-threatening.
- **Higher Risk of Addiction** (uncontrollable craving), especially for those with history of substance abuse or heavy alcohol use.

I understand there are strict rules for the use of opioid medications including:

- I will follow other treatments for my pain, including physical or psychological therapy and non-opioid medications as ordered by my provider.
- I will attend all follow-up appointments and do all ordered labs tests (urine, blood, or EKG).
- I will not drive a motor vehicle or operate machinery (if CDCR job requires) that could risk my own or other’s safety.
- I must tell the provider any and all effects I have from this medication.
- I will not share this medication with others, or take it other than as prescribed.
- I will keep a positive relationship with my provider, and understand that I may need to renew this consent upon transfer of care.
- I will not drink alcohol or take illegal drugs while on opioids.

I understand that if I break this agreement in any way, my provider will stop prescribing me opioid medications.

Examples of reasons to stop prescribing me opioid medications include, but are not limited to:

- Not cooperating with other treatments such as physical or psychological therapy or other medication.
- Suspicion of hoarding/cheeking which may also result in the search of my housing unit.
- Sharing medication with other people or taking it in ways other than prescribed.
- Being angry or uncooperative with healthcare staff. A positive relationship is needed with your provider.
- Refusing any urine or blood screenings or missing scheduled follow-up appointments.
- If I am found to be using any illegal drugs (meth, cocaine, marijuana or others).
- Signs of addiction.

My signature below indicates that I have reviewed the above with my provider, and understand the terms of opioid treatment. I also authorize my provider to notify custody if any circumstance related to this treatment causes concerns for my safety or that of others.

Patient Signature: __________________________ Provider Signature: __________________________ Date/Time: __________

<table>
<thead>
<tr>
<th>1. Disability Code:</th>
<th>2. Accommodation:</th>
<th>3. Effective Communication:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TABE score ≤ 4.0</td>
<td>Additional time</td>
<td>Patient asked questions</td>
</tr>
<tr>
<td>DPH DPM CLD</td>
<td>Equipment SU</td>
<td>Patient summed information</td>
</tr>
<tr>
<td>DPA DPH DNH</td>
<td>Louder Slower</td>
<td>Please check:*</td>
</tr>
<tr>
<td>DDP</td>
<td>Basic Transcribe</td>
<td>Not reached* Reach</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>Other*</td>
<td>*See chronnotes</td>
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<td></td>
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</tbody>
</table>

CDCR #:  
Last Name:  
First Name:  
DOB:  

Unauthorized collection, creation, use, disclosure, modification or destruction of personally identifiable information and/or protected health information may subject individuals to civil liability under applicable federal and state law.
Doy mi consentimiento para que (mi proveedor) recete medicamentos opiáceos como parte de mi plan de tratamiento para el dolor crónico.

Entiendo que los medicamentos opiáceos presentan riesgos mayores incluyendo:
- **Efectos secundarios** como mareos, comezón, somnolencia, náuseas, respiración lenta, estreñimiento, entre otros.
- **Riesgo de una sobredosis**, especialmente si se usan en combinación con otros medicamentos, alcohol o drogas ilegales. Esto puede causar la muerte al parar la respiración.
- **Una dependencia física** se puede desarrollar con el uso continuo y es posible que se requiera una dosis mayor. Si se interrumpe abruptamente la medicación, se pueden experimentar síntomas de abstinencia (síntomas similares a la gripa: náuseas, diarrea, dolor, sudoración, escalofríos, irritabilidad, temblores y confusión) que son incómodos, pero no amenazan la vida.
- **Un riesgo más alto de adicción** (deseos incontrolables), especialmente para aquellos con antecedentes de consumo de drogas o alto consumo de alcohol.

Entiendo que hay reglas estrictas para el uso de medicamentos opiáceos incluyendo:
- Seguiré otros tratamientos para mi dolor, incluida la terapia física o psicológica y medicamentos sin opioides, como lo ordene mi proveedor.
- Asistiré a las citas de seguimiento y me someteré a todas las pruebas de laboratorio ordenadas (orina, sangre o electrocardiogramas).
- No conduciré vehículos automotores ni operaré maquinaria (si el trabajo en el Departamento Correccional y de Rehabilitación de California [California Department of Corrections and Rehabilitation, CDCR] lo exige) que pudiera suponer un riesgo para mi seguridad o la de otras personas.
- Debo informar al médico todo y cualquier efecto que experimente con este medicamento.
- No compartiré este medicamento con otras personas, ni lo tomaré de otra manera que no sea la prescrita.
- Mantendré una relación positiva con mi proveedor y entiendo que es posible que deba renovar este consentimiento cuando mi cuidado se transfiera.
- No tomaré alcohol ni drogas ilegales mientras esté tomando los analgésicos opiáceos.

Entiendo que si no cumple este acuerdo de cualquier manera, mi médico dejará de recetarme medicamentos opiáceos.

Ejemplos de razones para suspender los medicamentos opiáceos incluyen, entre otros:
- Falta de cooperación con en otros tratamientos como terapia física o terapia cognitivo-conductual o otros medicamentos.
- Si se sospecha que estoy almacenando el medicamento o escondiéndolo en la boca en vez de tragarlo, esto podría resultar en la inspección de mi unidad de vivienda.
- Si comparto el medicamento con otras personas o lo tomo de otra manera que no sea la prescrita.
- Si me enojo o dejo de cooperar con el personal de atención médica. Una relación positiva es necesaria con su proveedor.
- Si rehuso cualquier análisis de orina o de sangre, o faltó a citas de seguimiento programadas.
- Si se descubre que estoy usando cualquier droga ilegal (metanfetamina, cocaína, marihuana u otras).
- Si manifesté síntomas de adicción.

Mi firma a continuación indica que revisé la anterior con mi proveedor y que entiendo los términos y condiciones del tratamiento con opioides. También autorizo a mi proveedor a informar al custodio sobre cualquier circunstancia relacionada con este tratamiento que cause alguna inquietud por mi seguridad o la de otros.

Patient Signature: ___________________________ Provider Signature: ___________________________ Date/Time: ____________

CDCR #: ____________

Last Name: ___________________________
First Name: ___________________________
DOB: ___________________________

1. Disability Code: 
   - TABE (Grade 1.0) 
   - DPH/DV/LD 
   - DPS/DNH 
   - DDP 
   - Not Applicable 
   
2. Accommodation: 
   - Additional time 
   - Equipment/SU 
   - Louder/Slower 
   - Basic/Transcribe 
   - Other *See chrononotes

3. Effective Communication: 
   - Patient asked questions 
   - Patient summed information 
   - Please check one: Not reached/Reached

4. Comments: