



Opioid Prescribing Tips & Tricks

CANDY STOCKTON, MD

MAY 2018

Disclosures

▶ None

Educational Objectives

- ▶ Understand CA state medical board guidelines for prescribing opioids for chronic pain
- ▶ Understand the CDC Guidelines for for prescribing opioids
- ▶ Be able to identify the most common health risks associated with chronic opioid use
- ▶ Know how to document chronic opioid prescribing appropriately

California State Medical Board Guidelines

- ▶ Page 1: “not meant for the treatment of patients in hospice or palliative care settings and are not in any way intended to limit treatment where improved function is not anticipated and pain relief is the primary goal”

California State Medical Board Guidelines – Acute Pain

- ▶ Opioids should not be first line therapy
- ▶ Prescribed “for a short duration”
- ▶ Do not use long/intermediate acting opioids

California State Medical Board Guidelines – Initiating Treatment

- ▶ Risk stratification (ORT)
- ▶ Establish a diagnosis
- ▶ Non-Opioid Treatment options
- ▶ Evaluate benefits & risks of therapy
- ▶ Aberrant behaviors
- ▶ Urine drug testing
- ▶ Review CURES
- ▶ Develop reasonable treatment goals
- ▶ Pain Management Agreement
- ▶ Patient Consent for Treatment
- ▶ Educate about signs/symptoms of overdose
- ▶ Start opioids as a trial and assess against Treatment Goals
- ▶ Don't escalate above 80 MME without specialty consult

California State Medical Board Guidelines – Monitoring Treatment

- ▶ Evidence of progress toward treatment objectives
- ▶ Absence of substantial risks or adverse events
- ▶ 5 A's
 - ▶ Analgesia
 - ▶ Activity
 - ▶ Adverse
 - ▶ Aberrance
 - ▶ Affect
- ▶ CURES
- ▶ Drug testing
- ▶ Pill Counts
- ▶ Exit Strategy
 - ▶ Referral to Addiction Medicine
 - ▶ Taper when appropriate (10%/week)
 - ▶ Terminate particular medication, not patient care



SB-482

- ▶ DOJ certified the CURES database on 4/2/2018
- ▶ Mandatory CURES consultation becomes effective on 10/2/2018
- ▶ Check
 - ▶ Before prescribing all new schedule II, III, or IV med (within 1 business day)
 - ▶ At least every 4 months while continuing treatment

CDC Guidelines

- ▶ Use Non-Pharmacologic Treatments and Non-Opioid Meds before considering Opioids. Document these.
- ▶ Start with immediate-release opioids for chronic pain
- ▶ Use the lowest effective dosage. Stay <50 morphine milligram equivalents (MME)/day, avoid increasing dosage to ≥90 MME/day or carefully justify
- ▶ Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- ▶ Reevaluate every 3 months. 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.
- ▶ PDMP q 3 months, Urine drug testing at least annually.
- ▶ Co-prescribe naloxone
- ▶ No Benzos

“New Starts”: before you prescribe

- ▶ Discuss the risks (respiratory depression; increased risk of falls, accidents, and fractures; constipation and urinary retention; cognitive impairment and depression)
- ▶ Complete an ORT; add an oximetry and/or DEXA scan if high risk
- ▶ Urine toxicology
- ▶ Set specific goals of treatment
- ▶ Have an end plan

Monitoring Established Patients

- ▶ Urine Toxicology
- ▶ CURES
- ▶ Functional Status
- ▶ Respiratory suppression/Nocturnal Hypoxia
- ▶ DEXA Scan
- ▶ Testosterone levels (men)
- ▶ Contraception (women)
- ▶ EKG (methadone only)

Urine Toxicology

- ▶ Always ask before you test and document the answers
- ▶ What do your results mean? Are you sure?
- ▶ Toxicology:
 - ▶ Q6 months: Low risk ORT, low dose treatment (<40 mg MED), no previous abnormalities
 - ▶ Q3 months: moderate risk ORT, intermediate range treatment (40-99 mg MED), previous alcohol or THC in the last year
 - ▶ Monthly: consider if patient has high risk ORT, high dose therapy (>100 mg MED), multiple previous positives for alcohol/THC in the last year, any positive for illicit drugs

CURES

- ▶ Current Law: Required to have a CURES registration and log-in. You are not required to use it.
- ▶ State Law (SB482) will go into effect 10/02/2018.
 - ▶ Before each new prescription for Schedule II-IV meds
 - ▶ Every 4 months while prescribing

Functional Status

- ▶ Pain is not an objective measurement and is variable depending on many circumstances.
- ▶ Set realistic goals and reassess regularly

Safety Parameters

- ▶ Overnight oximetry (smokers, overweight, >40 MME)
- ▶ DEXA Scan (smokers, high dose therapy, postmenopausal women)
- ▶ Testosterone can be decreased by as much as 50% in men using opioids (women are less affected). All men on regular opioid therapy should be assessed.
- ▶ Contraception (All women of child-bearing age.)

Documentation

- ▶ Most recent comprehensive pain evaluation
- ▶ Pain Sources
- ▶ Interval hx
- ▶ 4 A's

Documentation

- ▶ Comprehensive pain evaluation: 10/17/2016, reviewed & updated 11/1/17.
- ▶ Pain Sources: DDD C-spine, chronic tension headaches, bilateral knee OA
- ▶ Interval hx: Difficult month, husband recently diagnosed with colon cancer and she is having to do more around the house.
- ▶ 4 A's
 - ▶ Analgesia: Patty continues to report moderate improvement in pain with her medications which lasts for 4-5 hours after each dose.
 - ▶ Activity: She is able to do her own laundry and housekeeping. She walks 30 minutes 5x/week for exercise.
 - ▶ Adverse: only mild constipation which is managed with prn colace
 - ▶ Aberrant: no early refill requests/lost meds. Urine tox consistently appropriate. Denies use of alcohol, THC or other non-prescribed substances.

Example PM Summary

- ▶ PMA/Informed consent: 06/2017
- ▶ MME: 40mg daily (+/- benzos & sedatives)
- ▶ ORT: 3 [low risk]
- ▶ CURES: as expected, 09/12/2017
- ▶ UTox: as expected, 10/17/2017. EtOH present on 06/2017.
- ▶ Oximetry: known sleep apnea, confirms CPAP use
- ▶ DEXA: 12/2017; osteopenia 10 yr fx risk 4.6%
- ▶ Testosterone: 03/2017, wnl OR Contraception: hysterectomy 1997
- ▶ Naloxone: refused 11/2017
- ▶ Next visit due: March 2018

Tapering Medications

- ▶ Pick your battles. The goal is to keep the patient engaged in appropriate treatment.
- ▶ Let the patient pick which med to start with
 - ▶ Benzos
 - ▶ Smoking
 - ▶ Sleeping pill
 - ▶ One opioid (5-10% dosing intervals)
- ▶ Self Directed Taper

Managing Refills & Follow Up Appointments

- ▶ When possible, put fill dates on your Rx's
- ▶ Set reminders for your refills
- ▶ Refills for patient's who are due/overdue for follow up

Managing Refills & Follow Up Appointments

- ▶ When possible, put fill dates on your Rx's
 - ▶ "Ok to fill on 1/06/18, next Rx due 2/5/18. "
- ▶ Set reminders for your refills

- ▶ Refills for patient's who are due/overdue for follow up

Managing Refills & Follow Up Appointments

- ▶ When possible, put fill dates on your Rx's
- ▶ Set reminders for your refills
 - ▶ Example: Rx's for MSContin & Hydrocodone due on 2/1/18. Decreasing hydrocodone by 10 tablets. Next appt due early April.
 - ▶ Multiple providers filling medications is a "Red Flag" for the DEA and increases the risks of unintentional errors
- ▶ Refills for patient's who are due/overdue for follow up

Managing Refills & Follow Up Appointments

- ▶ When possible, put fill dates on your Rx's
- ▶ Set reminders for your refills
- ▶ Refills for patient's who are due/overdue for follow up
 - ▶ Schedule follow up before refilling med

State Medical Board Cases

- ▶ Documentation
 - ▶ CURES monitoring
 - ▶ Urine Toxicology
 - ▶ Co-Prescribing Narcan
 - ▶ Multi-Modal Treatment
 - ▶ Timely follow up
- ▶ Red Flags
 - ▶ Calls from pharmacies/family members
 - ▶ Aberrant Urine Toxicology or CURES
 - ▶ Untreated sleep apnea or nocturnal hypoxia
 - ▶ ED visits/hospitalizations for OD or impaired consciousness

Special Considerations: Methadone

- ▶ QT Prolongation: monitor the QTc
- ▶ Be aware of the MME's
- ▶ **Birth control!!!!**
- ▶ Medication interactions
 - ▶ Increase levels: Fluconazole, Fluvoxamine, Ketoconazole, Quetiapine
 - ▶ Decrease levels: Carbamazepine, Phenobarbital, Phenytoin, Rifampicin

Online Info

Jun 21, 2014

#1



Adicted
Newbie

Reputation Points: **100**
Messages: 66
Joined: Jun 14, 2014
34 y/o from Spain

I'm on **methadone** maintenance since 2004 with a daily dose of 140 mg.

Every Monday I go to the health center and give me seven doses for the week, 14 tablets of 70 mg. Sometimes I buy Extra **methadone** on the black market to take very high doses and combining it with **benzos** to get high.

But there are three ways to enhance **methadone** that can do all three at once. The first is grapefruit juice. Drinking a glass of grapefruit juice 15 minutes before taking **methadone** will increase blood levels of the **opioid** by inhibition of metabolism.

Another product that power **methadone** is omeprazole. Take 20-40 mg. omeprazole 20 minutes before taking **methadone** increase **methadone** levels in the body. And the last is **diazepam** and **alprazolam** (**Xanax** and Valium). Taking **Xanax** and / or Valium with **methadone** increase the concentration of **methadone** in the CNS enhancing its effect.

You can do all three things together: taking omeprazole 20 minutes before taking **methadone**, drink grapefruit juice 15 minutes before **methadone** and taking **Xanax** and / or Valium with **methadone**. So the effect of your **methadone** dose is multiplied.

Last edited by a moderator: Jun 25, 2014

HTML:

The following drugs increase the potency of Methadone:

Fluconazole (Diflucan), a synthetic triazole antifungal agent, can raise methadone levels by 30%.

Ketaconazole (Nizoral), indicated for fungal infections.

The antidepressants Amitriptyline (Elavil) and Fluvoxamine (Luvox)

Diazepam (Valium) and similar anti-anxiety drugs like Xanax or Halcion.

Cimetidine (Tagamet), used in the treatment of ulcers and acid reflux heartburn.

Urinary alkalinizers (Bicitra, Polycitra) used to treat gout and kidney stones.

Hydroxyzine (Vistaril), a sedative antihistamine, boosts potency by 50%.

The following drugs decrease the potency of Methadone:

Rifampin

Viramune (Nevirapine)

Carbamazepine (Tegretol) and Phenytoin (Dilantin)

Vitamin C

Hi all,

This is just some info on the topic that **SWIM** picked up elsewhere. He believes it originated from the now deceased coldwaterworld.com.

Hope others in **SWIM**'s position find it of help.

Being a responsible SWIMMER, he should add that it is for informational purposes only, and those seeking to follow any of the tips should be VERY careful and be aware that they may be playing with fire!

I am going to try the Tamaget and Vistoril methods. Has anyone used either of those for **opioid**/opiate potentiation in the past? He could do with knowing when he should actually take said drugs, in order for them to work properly with the **meth**. Any tips?

Special Considerations: Pregnancy

- ▶ Contraception!!!!
- ▶ Risk for NAS

Special Considerations: Benzo's and Psychiatry

- ▶ No easy answers here