Chronic opioid pain mgmt policy
Version 2012-02-13

Assess if opioid therapy (i.e. Protocol) appropriate

Automatic Exclusions from Protocol:
- **Contraindication(s) to opioids**
  - Adverse reaction
  - Untreated addiction
  - Substantial risk for adverse event
- **Too high dose**
  - >=120 mg morphine equivalent daily
- **Multiple (>1) practice dismissals**
  - Due to pain meds/abuse

→
- **No opioids**
- **Use other options**
- **Consider referral to pain specialist**

See Page 2 for MAX dose calculation

Prior opioid pain therapy?

No opioids are to be prescribed at first visit

Request records
If physician records not available (such as with office closing, obtain pharmacy fill records)

Protocol exclusion: Prompt receipt of records not matching patient report
→
- **No opioids**
- **Use other options**
- **Consider referral to pain specialist**

If delayed records do not match patient report, provider discretion

Prior dismissal from single practice?

Review records/speak to discharging physician
→ **Protocol OK if provider deems risk low (e.g. does not agree with reason for dismissal)**

Functional improvement?
(Previously or with limited trial)

No →
- **Use other options**
- **Consider referral to pain specialist**

Exhausted non-opioid options?
- **Non-opioid medications**
  - Acetaminophen
  - NSAID(s)
  - Tramadol (if appropriate)
- **Non-drug therapies**
  - Physical therapy
  - Diet Modifications
  - Activity Modifications
  - Other physical treatments
- **Adjunct medications**
  - Antiepileptics
  - Antidepressants

No → **Trial of appropriate non-opioid option(s)**

Has had appropriate imaging/ testing/ specialist evaluation?
To adequately evaluate and document the problem
- Xrays
- MRI
- EMG
- Neuro eval
- Ortho eval
- Psych eval

No → **Proceed with appropriate workup/referrals**
Prior to or concurrent with initiating opioid

Permitted disclosures of Protected Health Information
related to chronic pain therapy/ controlled substances

Law enforcement purposes:
(Provider) may disclose protected health information to law enforcement officials for law enforcement purposes under the following...circumstances...
- as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests
- when (provider) believes that protected health information is evidence of a crime that occurred on its premises

(paraphrased from Summary of the HIPAA Privacy Rule from US Dept of Health and Human Services)

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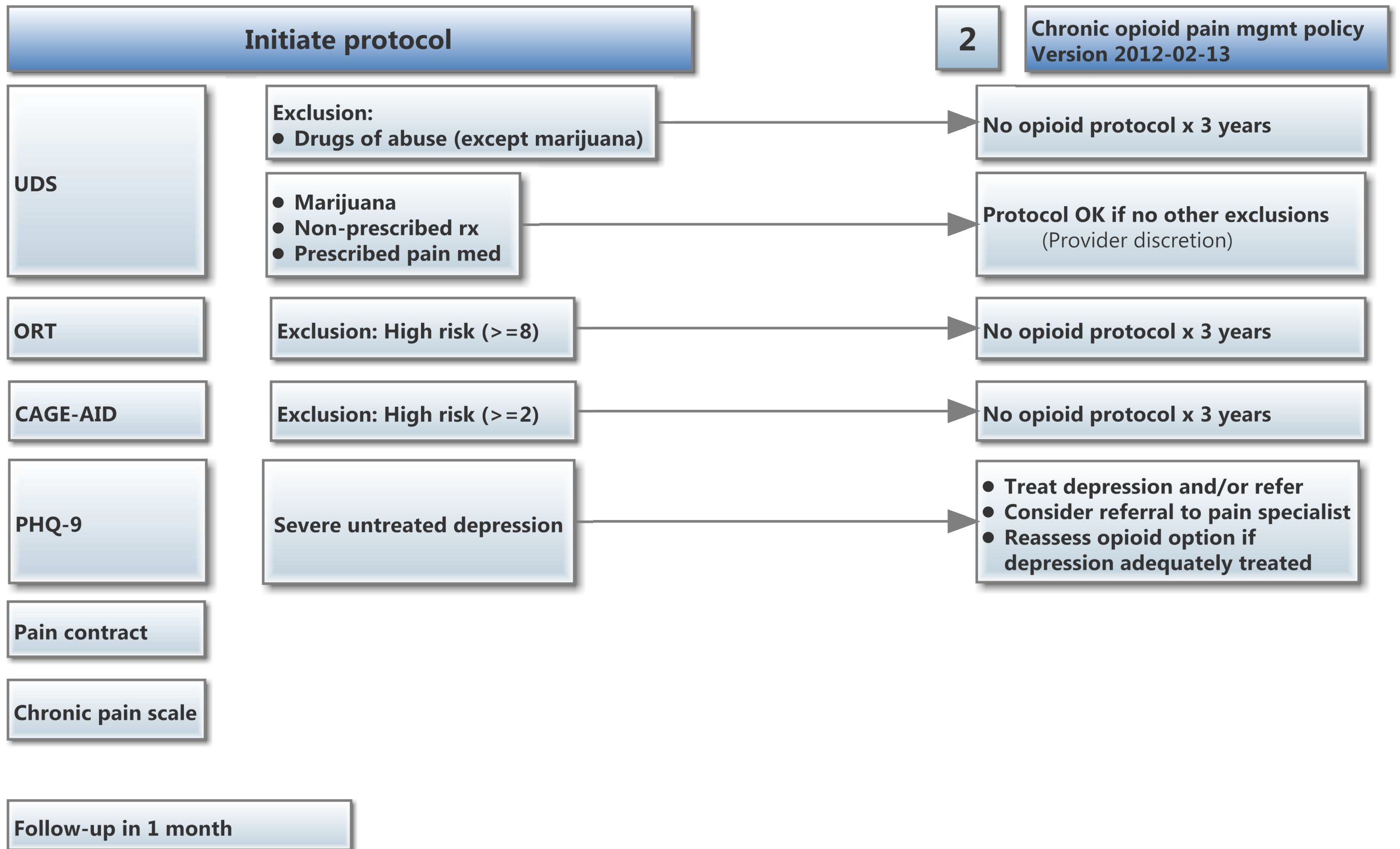

MAXIMUM daily doses for Protocol

>= these doses triggers referral to specialist (Do not start protocol if presents on >= max dose.)

Morphine	**120 mg daily**	**Example: MS Contin 60 mg twice daily**
Based on morphine equivalents:		
Fentanyl	**50 mcg/hr**	**Example: Duragesic 50 mcg/hr patch**
Hydrocodone	**120 mg daily**	**Example: Vicodin; Note: Acetaminophen max daily dose = 4 grams**
Hydromorophone	**30 mg**	**Example: Dilaudid 30 mg total daily**
Methadone (chronic)	**16 mg daily**	**Example: Methadone 10 mg + 5 mg daily**
Oxycodone	**80 mg daily**	**Example: Oxycontin 40 mg twice daily**
Based on safety:		
Codeine	**360 mg daily**	**Note: Acetaminophen max daily dose = 4 grams**

Conversion factors for calculating MAXIMUM daily dose for Protocol

These conversion factors are to be used only to determine the maximum dose allowable under this protocol, not for transition from one opioid to another. (For those cases, the MED should be used to calculate an approximate equivalent dose, with subsequent appropriate reduction of dose to account for incomplete cross-tolerance of the opioids.)

Opioid	Equianalgesic Dose (mg) Oral or transdermal	Westside conversion factor
Morphine	**30 mg**	**1**
Hydromorphone	**7.5 mg**	**4**
Codeine	**200 mg**	**0.15**
Fentanyl transdermal	**12.5mcg/hr**	**2.4**
Hydrocodone	**30 mg**	**1**
Methadone- chronic	**4 mg**	**7.5**
Oxycodone	**20 mg**	**1.5**
Oxymorphone	**10 mg**	**3**

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Maintenance

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General principles:

- Titrate cautiously only to improve function, limit pain
  (Max dose 120 mg morphine equiv daily)
- Transition most patients to long-acting meds
  Exceptions (intermittent/low doses of short-acting)
- Followup visits monthly, until stable for several months
  Then every 2-3 mo
- Prescriptions should be given only by "Designated Provider"
- Random UDS testing 3-4 times yearly (not every visit)
  More frequently at provider discretion
  If concern that UDS altered, immediately repeat

Automatic discontinuation of Protocol

Evidence of diversion
Selling or giving meds to others

Ongoing high-risk behavior
Drug overdose
Positive drug screens for drugs of abuse
except marijuana
Prescription tampering
Etc.

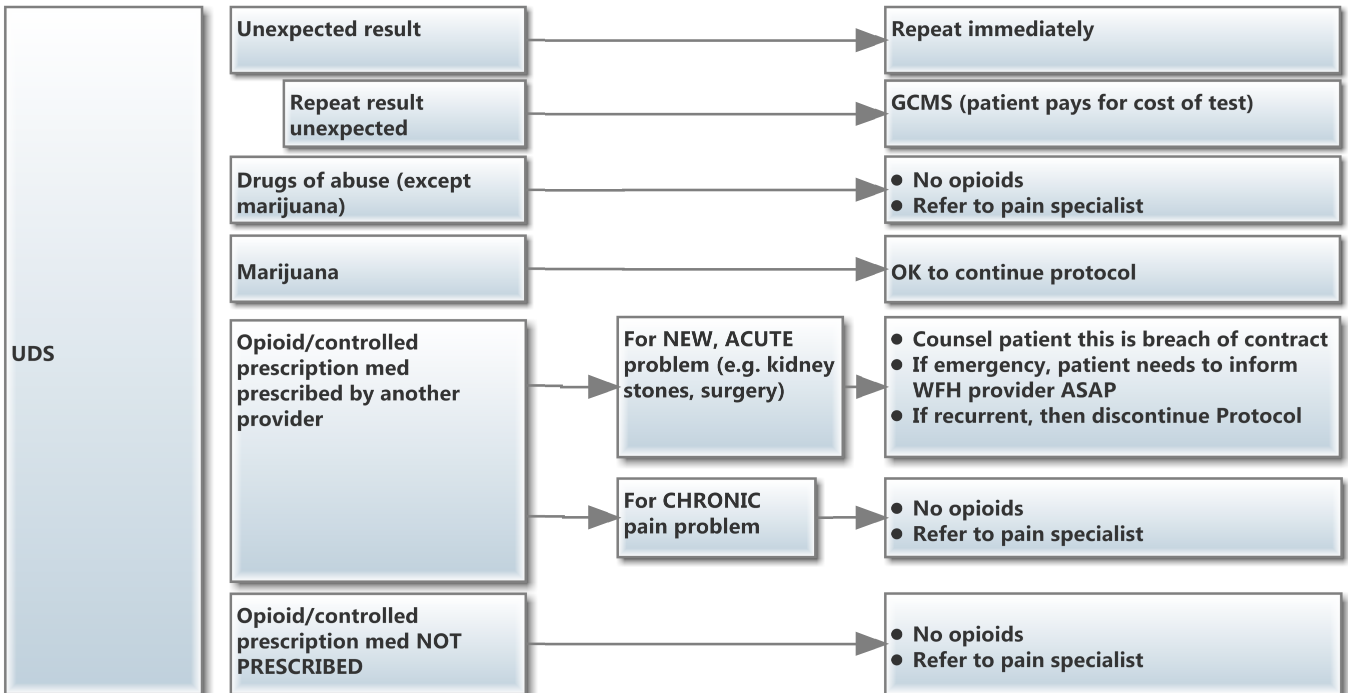
Each visit

Chronic pain scale (each visit)

- **No improvement in pain/function after adequate trial** → **Taper off opioids; Refer to pain specialist**

Titrate dose if needed

- **Not adequate response with 120 mg morphine equivalent daily?** → **Continue pain med at current dose and refer to pain specialist**



Yearly

- **ORT**
- **CAGE-AID**
- **PHQ-9**
- **Pain contract**

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Medication refills

At each visit

- Document "Date of next required appointment"
- Patient should plan to follow up with designated provider

Refills without office visit

- If clinically indicated, refills may be given without office visit
- "Date of next required appointment" indicates if office visit required for refill
- Maximum interval between visits = 3 months

Prescriptions should not be post-dated

Routine refill

- Patient calls 3-7 days prior to needing refill
- Nurse notifies designated provider of refill request
- Provider prints rx and gives to nurse
- Nurse contacts patient rx available

Medication pickup

- Picture identification required
- Nurse documents date, time, identify of person picking up
- If patient designee picking up, patient must notify nurse in advance of name of designee

Designated provider unavailable

- If anticipated provider absence → Provider makes prior arrangements for follow up with another provider
- If no prior arrangements → Any available provider should refill per established treatment plan
  - Treatment plan indicates next refill OK without visit → Medication should be refilled without visit
  - Treatment plan indicates next refill requires visit → Office visit required for refill
  - Interval concerns documented → Office visit required for refill

A patient should not be denied an appropriate refill of chronic opioid medication because his or her provider is unavailable

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