# Model opioid prescribing policy

This model policy was developed using the CDC Guidelines for Prescribing Opioids for Chronic Pain. It is an example policy clinics can modify and adopt when revising their policies.

**Revised**: DATE

**Next review date**: DATE

**Purpose**: To standardize prescribing guidelines for non-cancer opioid use.

**Scope: This policy covers treatment of patients prescribed opioids, both acutely and chronically. A patient on c**hronic opioid therapy (COT) shall be defined as any patient who has received, or is expected to receive, regular opioid prescriptions with duration of 90 days or longer.

## Prescribing opioids for acute pain

* Encourage the use of non-opioid and non-pharmacological modalities for acute pain
* Prescribe the lowest effective dose of immediate-release opioids for acute pain
* Prescribing 3 days or less of opioids will often be sufficient for acute pain; prescribe no greater than 7 days of opioids for acute pain
* Do not prescribe methadone or extended-release opioids for acute pain
* Do not refill acute opioid prescriptions without seeing patients

If opioids are prescribed for more than 3 months, this is chronic opioid therapy; review and sign an Opioid Patient Agreement with the patient.

## Initial prescribing of opioids for chronic pain

* Fully assess each patient to identify a diagnosis for their chronic pain
* Do not prescribe opioids for non-specific axial lower back pain, fibromyalgia, and chronic headaches
* Review and sign an opioid patient agreement
* Before prescribing opioids:
* Evaluate risk factors for opioid-related harms using the Opioid Risk Tool, or other guideline (AMDG or CDC) recommended opioid misuse assessment tool
* Check the state prescription monitoring program database to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose
* Conduct a urine drug test screening
* Only use opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient; review risks with the patient
* Avoid combination with sedatives, or sedative hypnotic drugs
* Inform patient that combination of opioids with alcohol may be lethal
* Prescribe naloxone “rescue” (nasal or injectable) to be administered by family or caregivers if patient is at higher doses (>50 mg MED), or at risk for overdose or risk of respiratory suppression due to sleep apnea.
* Combine opioids with nonpharmacologic and nonopioid pharmacologic therapy, as appropriate

### Prescription

* Only prescribe the lowest effective dose of immediate-release opioids
* Avoid increasing dosage to ≥50 MED/day or carefully justify a decision to titrate dosage to ≥90 MED/day

### Treatment goals

* Establish treatment goals with all patients before starting opioid therapy for chronic pain, including realistic goals for pain and function
* Within 1 to 4 weeks of starting opioid therapy for chronic pain, evaluate benefits and risks; ***only*** continue opioid therapy if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety

If opioids are prescribed for more than 3 months, this is chronic opioid therapy; review and sign an Opioid Patient Agreement with the patient.

## New patients already on chronic opioid therapy

* Notify all new patients that they might not receive opioids during the initial visit, even if they are currently taking prescription opioids from a previous clinician. Ask them to bring their medical records related to their chronic pain care to their first appointment.
* Perform the following procedures before deciding whether to continue the patient’s chronic opioid therapy:
* Risk assessment using the Opioid Risk Tool
* Urine drug test
* Review the state prescription monitoring program database
* Request and review medical records
* Calculate morphine equivalency
* If appropriate, implement a tapering protocol. A tapering plan need not be initiated at initial visit, and very slow opioid tapers as well as pauses in the taper allow gradual accommodation to lower opioid dosages.
* If the patient chooses not to follow the tapering regimen, they will not receive chronic opioid therapy from our organization. However, it is important to continue offering primary care to this patient.

## Managing patients established on chronic opioid therapy

### Assessment schedule

Use the following assessment schedule for patients on chronic opioid therapy.

|  |  |  |
| --- | --- | --- |
| Content | Measurement tool | Frequency |
| Risk for opioid dependence and addiction | Opioid Risk Tool (ORT) | Start of opioid therapy |
| ID current substances used | Urine drug test | Start of opioid therapy and at least every 6 months (random) |
| ID current medications prescribed | State prescription monitoring program | Start of opioid therapy and at least every 3 months |
| Informed consent & risk education | Patient Agreement | Start of chronic opioid therapy; annually |
| Calculation of morphine equivalent dosing | Morphine Equivalent Dose (MED) | Every change in opioid prescription |
| Patient function | Pain, Enjoyment, General activity (PEG) | Every appointment |
| Anxiety, depression | Patient Health Questionnaire (PHQ), GAD-7 | At least every 6 months |
| Opioid misuse | Current Opioid Misuse Measure (COMM) | As indicated as a measure of opioid misuse |
| PTSD | Primary Care PTSD Screen (PC-PTSD) | If elevated PHQ or GAD despite active treatment |
| Sleep apnea | STOPBang | When co-occurring risks (COPD; restrictive lung disease, including kyphosis or thoracic scoliosis; BMI > 28; snoring; fatigue; witnessed irregular breathing; MED > 50; concurrent use of benzodiazepines) |
| Fibromyalgia | Patient self-report survey for the assessment of fibromyalgia | As appropriate during diagnosis |

If there is evidence of use of non-prescribed substances that put a patient at risk, e.g., illicit drugs or controlled substances not approved by the clinician:

* Assess for substance use disorder
* Refer to behavioral health and counseling services
* Discontinue chronic opioid therapy by tapering the medication(s)
* Continue to care for patient’s medical needs other than opioid prescription

If a patient fails to present for a urine drug screen:

* Arrangements may be made for a “second chance” random urine drug screen
* If the patient fails to show a second time, discontinue chronic opioid therapy by tapering the medication(s) at a pace appropriate to urgency and risk
* Evaluate for, or refer to substance use disorder expert or program.
* Evidence of diversion requires discontinuing chronic opioid therapy treatment.

### Diagnosis and treatment

* At least annually assess the patient to identify the diagnosis for their chronic pain
* At least annually assess potential benefits of nonpharmacologic and nonopioid pharmacologic therapy
* Within 1 to 4 weeks of increasing dosage, evaluate benefits and risks; ***only*** continue increased dose if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety

### Co-prescribing

* Do not prescribe opioid pain medication and benzodiazepines or other sedative concurrently.
* Screen for concurrent use of benzodiazepines or other sedatives at each visit.
* Consult with any other prescriber found to have given the patient a drug which could interact with opioid analgesics (e.g. benzodiazepines, sedative-hypnotics, anxiolytics, or CNS depressants). If the other practitioner is not available, document attempts to contact the other practitioner in the patient’s healthcare record.

### High risk patients

* Patients on a dose of 90 MED/day or higher must have a pain specialist consultation
* Prescribe Naloxone when factors that increase risk for opioid overdose exist, such as
* History of overdose
* History of substance use disorder
* Sleep apnea proven
* Higher opioid dosages (≥50 MED/day)
* Concurrent benzodiazepine use
* Arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

### Refills

* Write opioid prescriptions for a maximum of 28 days so patients do not run out of medications on the weekend
* Do not provide an opioid refill until the patient has an up-to-date Opioid Patient Agreement, urine drug test, and state prescription monitoring program check to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose
* Patients should receive prescription refills from only one clinician (or their designee if not available)
* Prescriptions should be refilled at only one pharmacy
* Include indications for medication use on the prescription
* Require photo identification of the person picking up a prescription in the clinic
* Only give refills during business hours on Tuesdays, Wednesdays, and Thursdays
* Require 3 business days’ notice
* Do not refill opioids for lost, stolen, spilled, etc. medications unless in extraordinary circumstances (e.g., fire, natural disaster, etc.)
* Do not refill opioids if patient has previously overdosed on medications
* Do not refill opioids if patient is arrested or incarcerated related to legal or illegal drugs

## Discontinuation of opioids

Patients who meet any of the below criteria may have their medications discontinued at the discretion of the clinician. Discontinuation of opioids should be performed through a reasonable tapering program.

* Failure to follow the signed Opioid Patient Agreement
* Missed appointments at the minimal scheduled interval or regularly scheduled appointments
* Failure to comply with urine drug testing as requested
* Failure to comply with medical evaluation of pain complaint, such as refusal of diagnostic tests (e.g., radiology tests, stress test) or referrals (e.g., neurology, physical or occupational therapy, pain specialist, behavioral health or psychiatry)
* Failure to report treatment with controlled substances by other clinicians
* Urine drug testing results not consistent with clinician’s prescription plan
* Prescriptions that patient reports taking daily are not detected on urine drug test
* Patient tests positive for illicit substances
* Patient is abusive with language, aggressive, or intimidating to staff. This behavior may result in termination of both opioids and professional attendance

If the clinician chooses to discontinue the medication, the clinician will taper the medication to avoid withdrawal symptoms, as medically indicated. Tapering may unmask underlying Opioid Use Disorder and these patients should be offered Medication Assisted Therapy.

If opioids are terminated, a letter of medication termination, including potential treatment options, is sent to the patient and a copy placed in the medical record. In cases of serious violation of the treatment agreement, or the violation of the law, the prescribing clinician may want to terminate care for the patient at the organization. Such a decision must be reviewed and finalized by the Medical Director.

An MED calculator can be found [here](http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm).