West Virginia Pain Management Guidelines

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Clinical Pain Management Pharmacist,
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Learning Objectives

- Describe the best practices within pain management related to risk reduction strategies.
- Recall multi-modal pain management treatment plan options.

2016 CDC Chronic Pain Opioid Guidelines

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid 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 nonpharmacologic therapy and nonopioid 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 opioid 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.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (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, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
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 should 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. Clinicians should evaluate benefits and harms of continued therapy with patients 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.
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.
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.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

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

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

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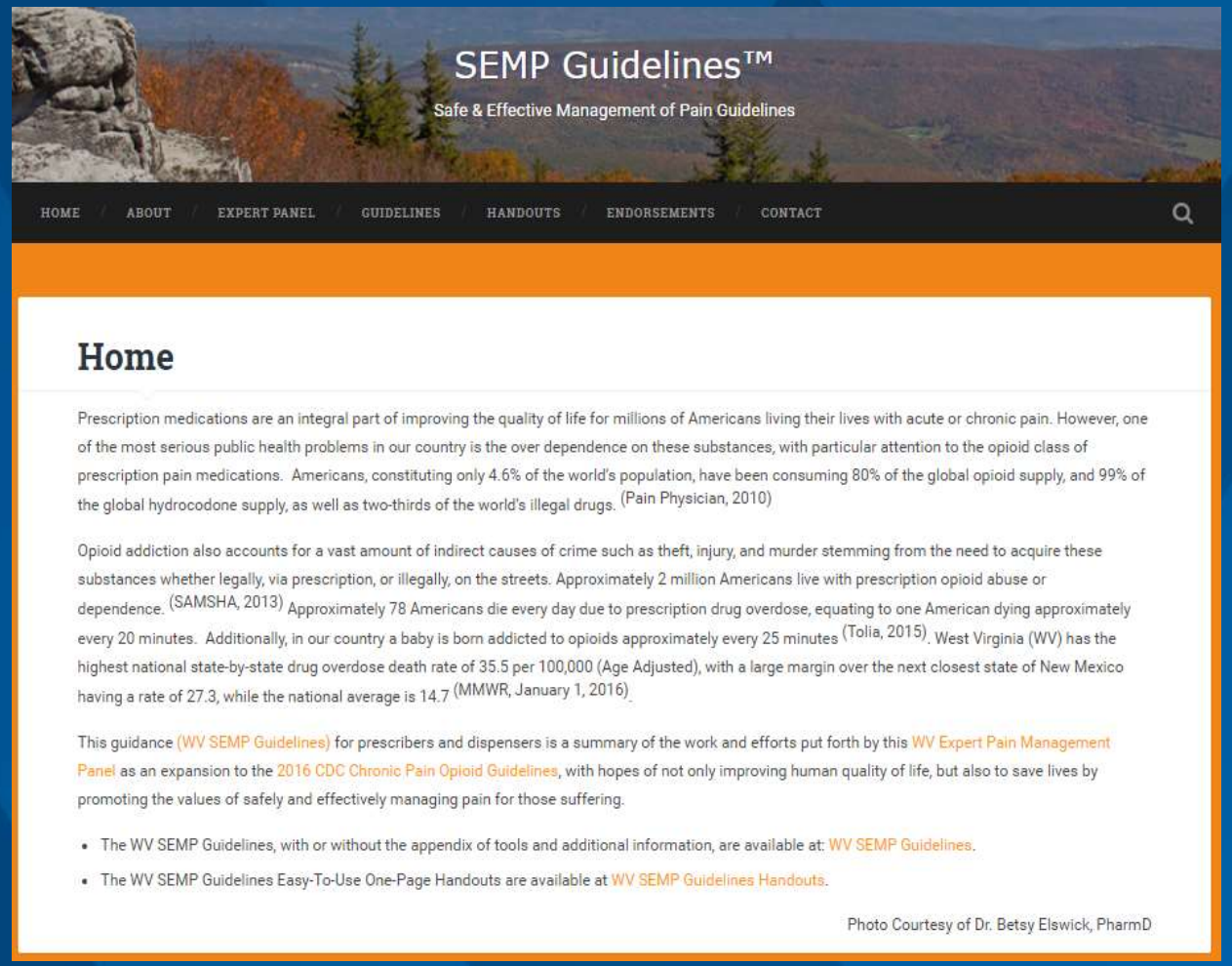
Expert Pain Management Panel

Panel Member	Organization/Title
Mark Garofoli, PharmD, MBA, BCGP, CPE (Coordinator)	Pharmacist
Timothy Deer, MD (Chairperson)	Medical Doctor
Richard Vaglienti, MD (Vice Chairperson)	Medical Doctor
Ahmet Ozturk, MD	Medical Doctor
Denzil Hawkinberry, MD	Medical Doctor
Bradley Hall, MD	Medical Doctor
Matt Cupp, MD	Medical Doctor
Rahul Gupta, MD	Medical Doctor (Public Health)
Michael Mills, DO	Osteopathic Doctor
Jimmy Adams, DO	Osteopathic Doctor
Richard Gross, PhD	Psychologist
Jason Roush, DDS	Dentist
Stacey Wyatt, RN	Registered Nurse
Vicki Cunningham, RPh	Pharmacist (Insurance)
Felice Joseph, RPh	Pharmacist (Insurance)
Stephen Small, RPh, MS	Pharmacist
Patty Johnston, RPh	Pharmacist
Charles Ponte, PharmD, CPE	Pharmacist
James Jeffries, MS	Health & Human Resources
Michael Goff	Retired State Policeman & PDMP Administrator

2016 West Virginia
Safe & Effective Management of Pain (SEMP) Guidelines



www.sempguidelines.org

	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1st Line	**Non-Pharmacological (Active & Passive)** APAP then +/-NSAID* Topical Agent (NSAID, Lidocaine, Capsaicin)	**Non-Pharmacological (Active & Passive)** Acute Trial of NSAID*/APAP Add on Topical Agent (NSAID, Lidocaine, Capsaicin) Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA)	**Non-Pharmacological (Active & Passive)** Acute Trial of NSAID*/APAP Topical Agent (NSAID, Lidocaine, Capsaicin)
2nd Line	Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**	Anti-Epileptic Drugs (AEDs) Controlled Substance Class IV **Consider Referral to Specialist**	Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**
3rd Line	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer*** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**	Combination 1st & 2nd Line Agents Acute Add-On Muscle Relaxer*** Controlled Substance Class III Interventional Therapy Controlled Substance Class II (IR) **Referral to Specialist Needed**
4th Line	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Botox Injection**** Consider Clinical Trial	Spinal Cord/Dorsal Root Ganglion Stimulation Controlled Substance Class II (ER) Implantable/Intrathecal (IT) Morphine/Baclofen/Ziconotide Consider Clinical Trial

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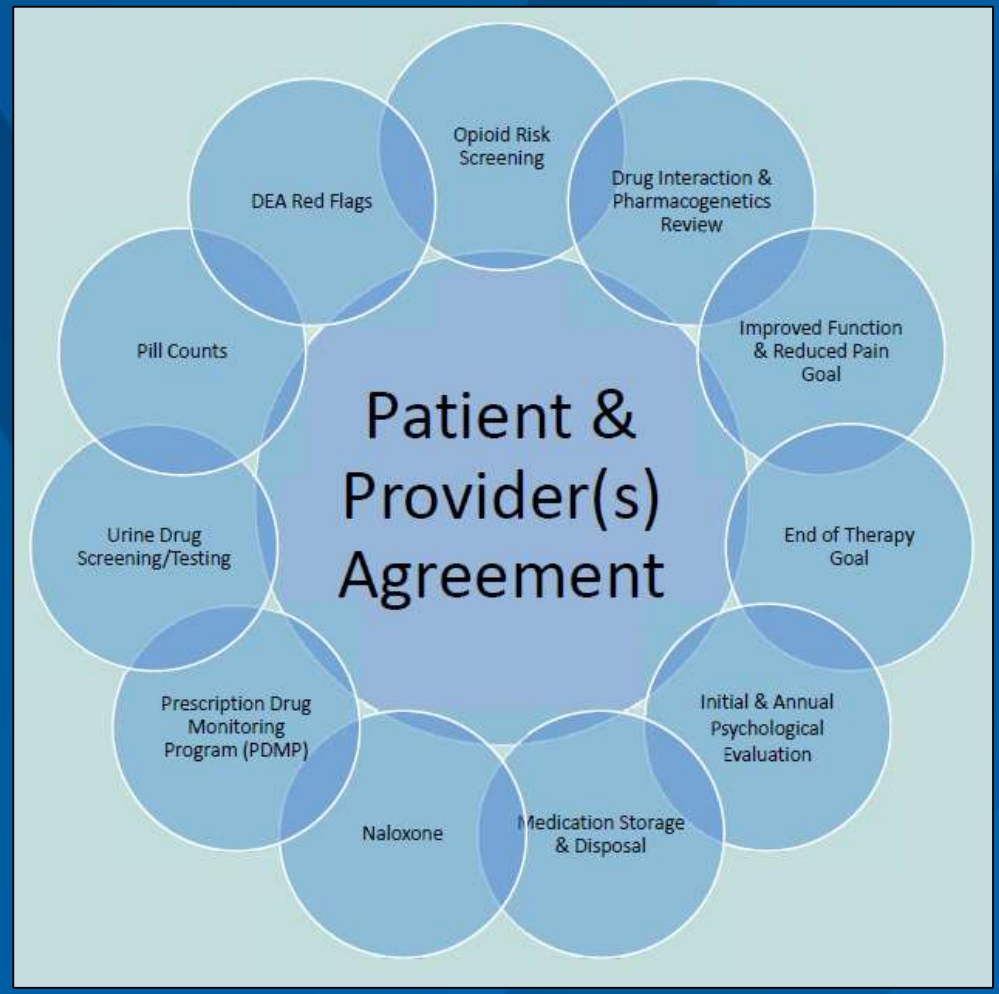

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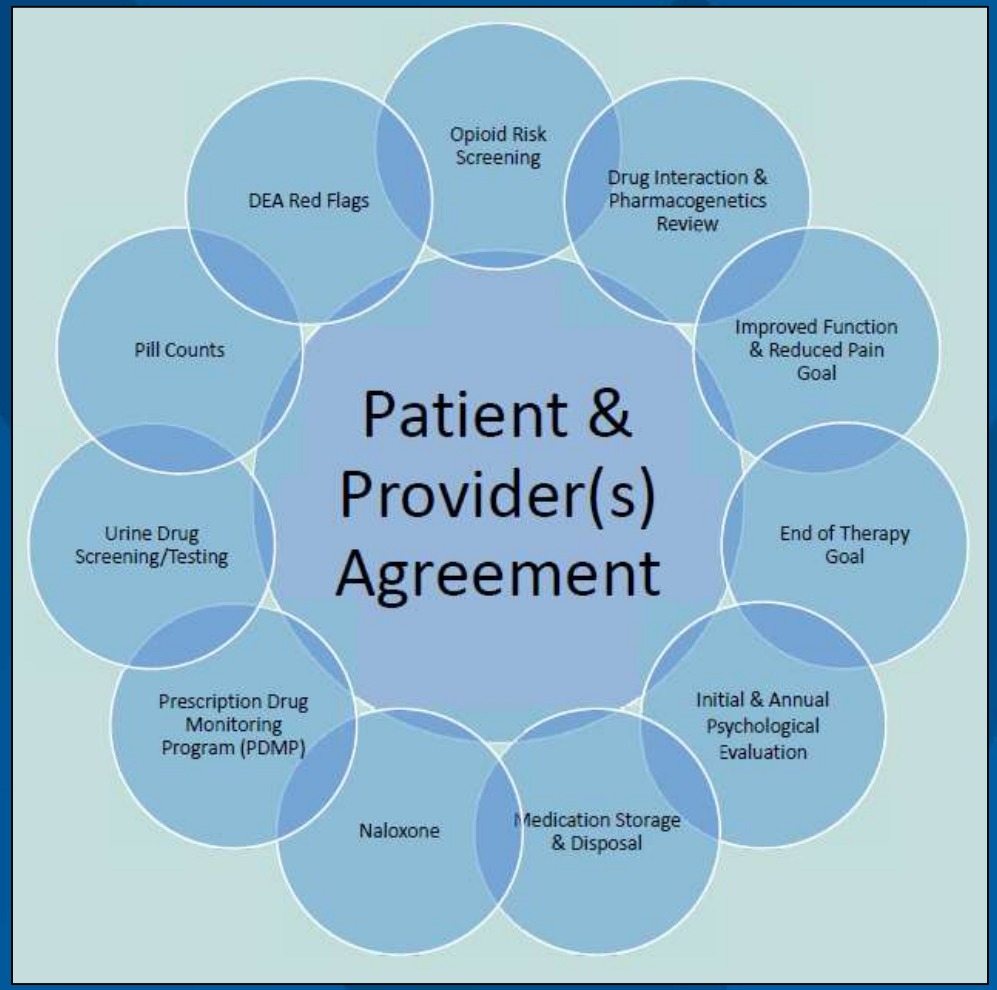
Risk Reduction Strategy



Patient & Provider Agreement Items

- Function & Time Goals
- Function, Pain, Risk, & Psychological Assessments
- Adverse effects of opioids
- PDMP
- Urine Drug Screening/Testing
- Naloxone Education/Supply
- Storage & Disposal
- Risks to others if shared
- Co-Manager if needed
- Contingency Plan

Pain Reduction & Function Improvement Goal

Pain = 5th Vital Sign ???

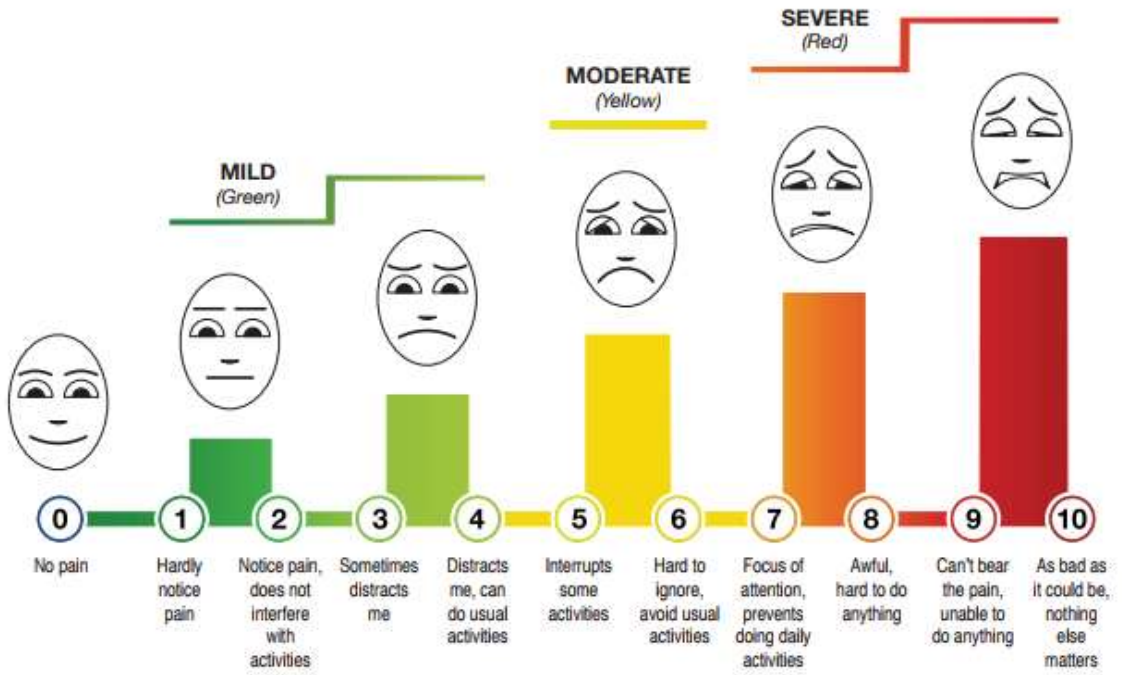
Analgesic ???

The goal is NOT necessarily to eliminate pain

- The goal is to Improve Function & Reduce Pain

DVPRS

Defense and Veterans Pain Rating Scale



v 2.0

DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute — Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

v 2.0

https://www.va.gov/PAINMANAGEMENT/docs/DVPRS_2slides_and_references.pdf

Proper Medication Storage

Proper Medication Disposal

FDA & EPA

1. DEA Sponsored Take-Back Programs
2. Household Trash
3. DEA Authorized Collector
4. Flushing a list of ~40 CIIs

Psychological Evaluation
PHQ-2 & PHQ-9

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ-2 Score >/= 3 → Take PHQ-9

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	_____	+ _____	+ _____	
Add Totals Together	_____			

PHQ-9 Score >/15 → Psychotherapy +/- Antidepressant

PHQ-2: http://www.cqaimh.org/pdf/tool_phq2.pdf
PHQ-9: https://www.mdcalc.com/phq-9-patient-health-questionnaire-9

Opioid Risk Screenings

Opioid Naïve

Self Reported

- Drug Abuse Screening Test (DAST)
- Screener & Opioid Assessment for Patients with Pain (SOAPP)

Provider Reported

- Opioid Risk Tool (ORT)
- Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)

Opioid Experienced

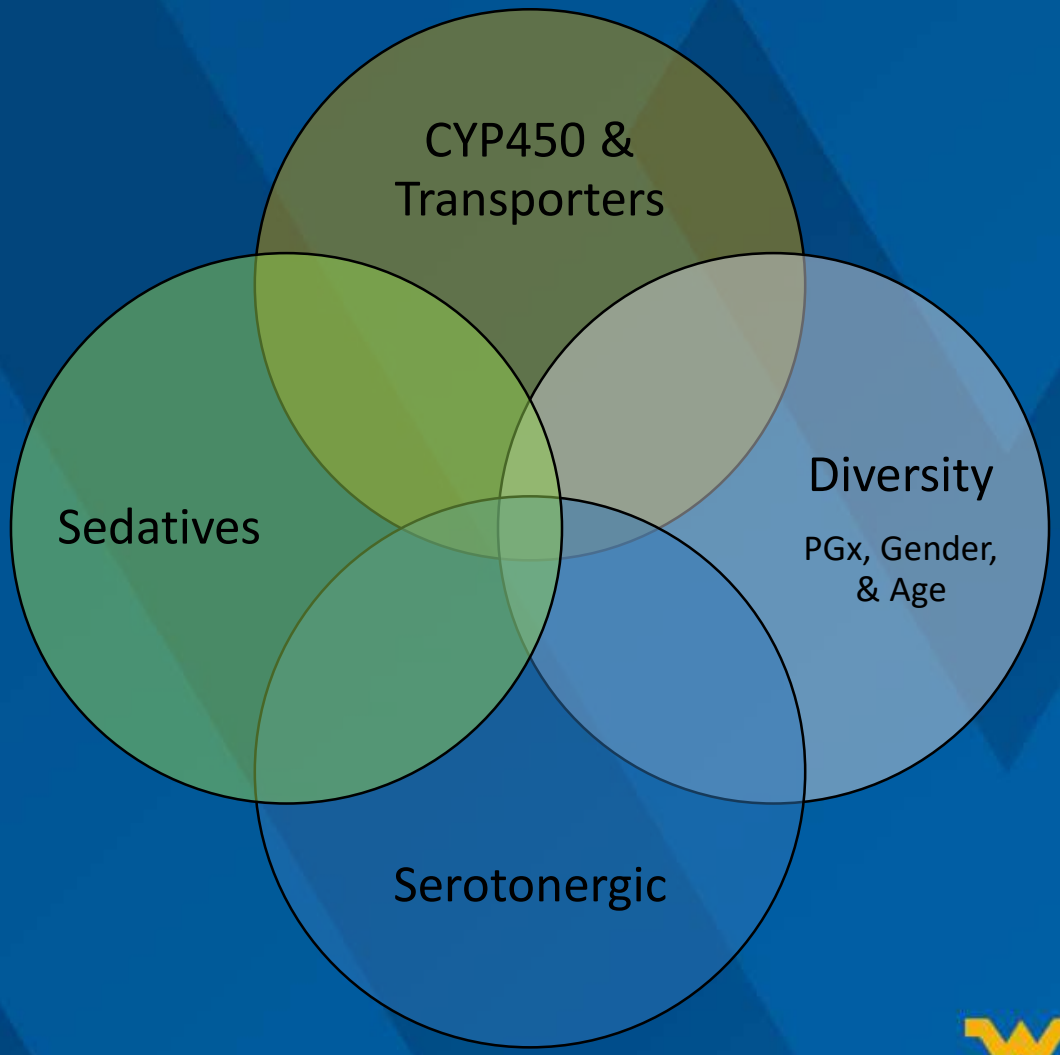
Self Reported

- Current Opioid Misuse Measure (COMM)
- Pain Medication Questionnaire (PMQ)
- Prescription Drug Use Questionnaire, Patient (PDUQp)

Provider Reported

- Prescription Drug Use Questionnaire (PDUQ)

Opioid Medication Interactions



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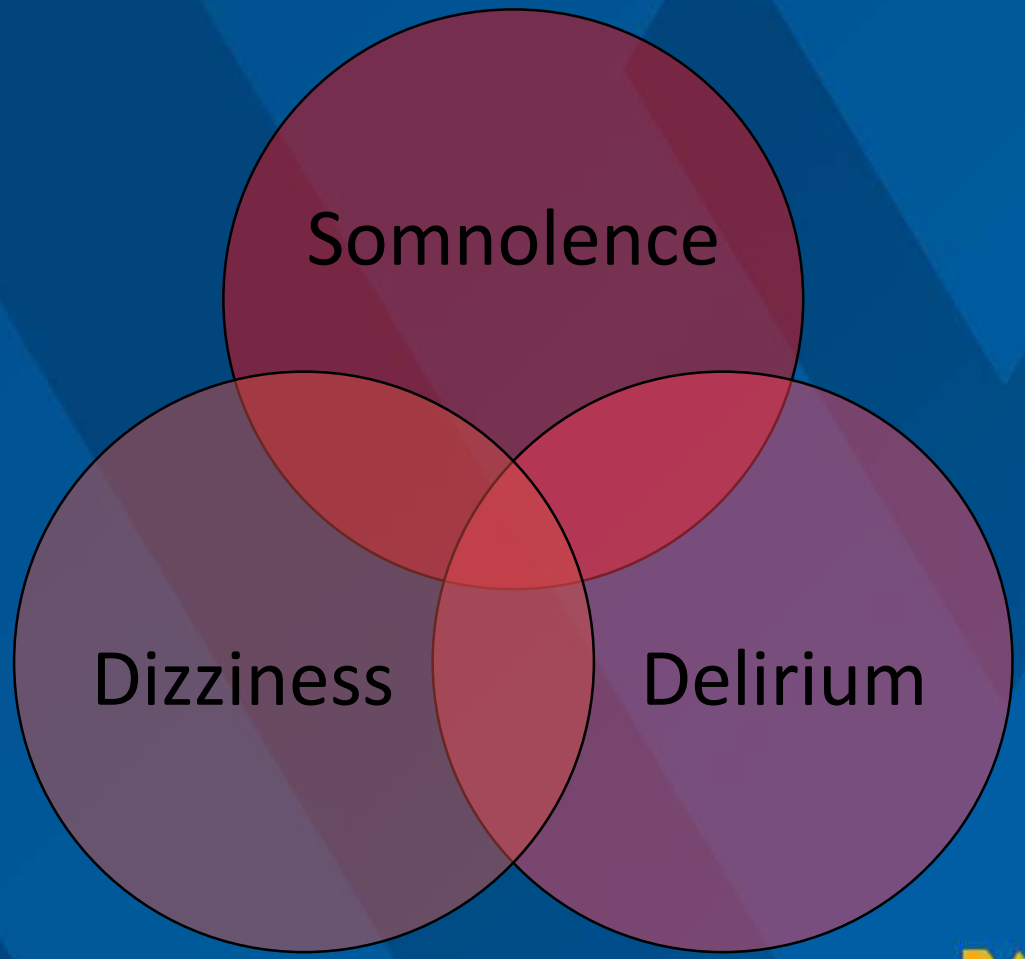
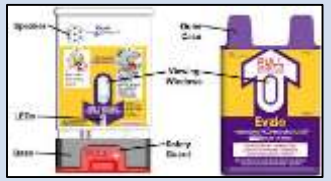
Opioids, Benzos, “Relaxants”, & Hypnotics

Overlapping Sedative Side Effects…



Naloxone Products

Product	Generic Injectable	Generic Intranasal	Narcan® Nasal Spray	Evzio® Auto-Injector
Dose	0.4mg IM	1mg in each nostril	4mg in one nostril	0.4mg/2mg IM/SQ
Dosing	Inject 1mL in shoulder/thigh, may repeat in 2-3min Use 3mL 23G syringe &1" needle	Spray 1mL (half of syringe) in each nostril with atomizer, may repeat in 2-3 min	Spray 0.1mL into one nostril; may repeat in 2-3 min with 2nd device in alternate nostril	Press black side firmly onto outer thigh through clothing, hold 5 seconds, may repeat in 2-3 min
Availability	0.4mg/mL 4mg/10mL	2mL prefilled Luer-Jet syringe + Atomizer (Item # MAD-301)	0.4mg/0.1mL	0.4mg/0.4mL 2mg/0.4mL
Manufacturer	Pfizer, West-Ward, & Mylan	IMS/Amphastar	Adapt	Kaleo
Cost	$	$$	$$	$$$$$
NDC	00409-1215-01 00409-1219-01 67457-0292-01 00641-6132-25	76329-3369-01	69547-0353-02	60842-0030-01 60842-0051-01
Picture				

Adapted from: Toderika Y, Williams S. Naloxone for Opioid Overdose and the Role of the Pharmacist. Consult Pharm. 2018 Feb 1;33(2):98-104.

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Urine Drug Screening/Testing

Conversation Starters

Conversation Leaders

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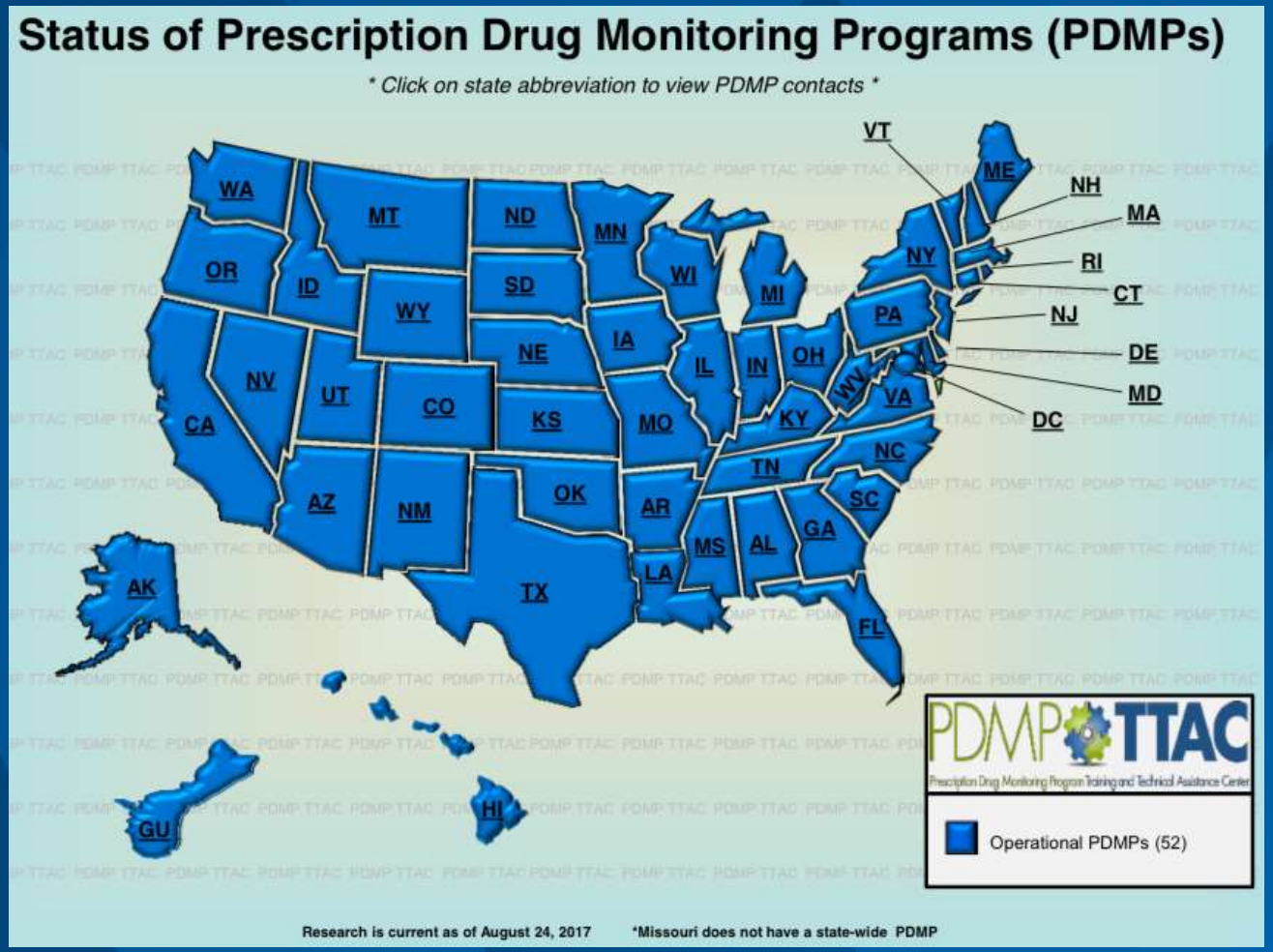
Prescription Drug Monitoring Programs

PDMPs



DEA Red Flags

Prescribers

- Cash only patients
- Prescribing of the same combination of highly-abused drugs
- Prescribing the same (high) quantities to most patients
- High number of prescriptions issued per day
- Out-of-area patient population

Dispensers

- Dispensing a high percentage controlled to non-controlled drugs
- Dispensing high volumes of controlled substances generally
- Dispensing the same drugs & quantities prescribed by the same prescriber
- Dispensing to out-of area or out-of-state patients
- Dispensing to multiple patients with the same last name or address
- Sequential prescription #s for highly diverted drugs from same prescriber
- Dispensing for patients of controlled substances from multiple practitioners
- Dispensing for patients seeking early prescription fills

NABP ”Red Flags” Video
(https://nabp.pharmacy/initiatives/awarxe/pharmacist-resources/)

https://nabp.pharmacy/initiatives/awarxe/pharmacist-resources/

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Once Drug Seeking or Diversion is Confirmed

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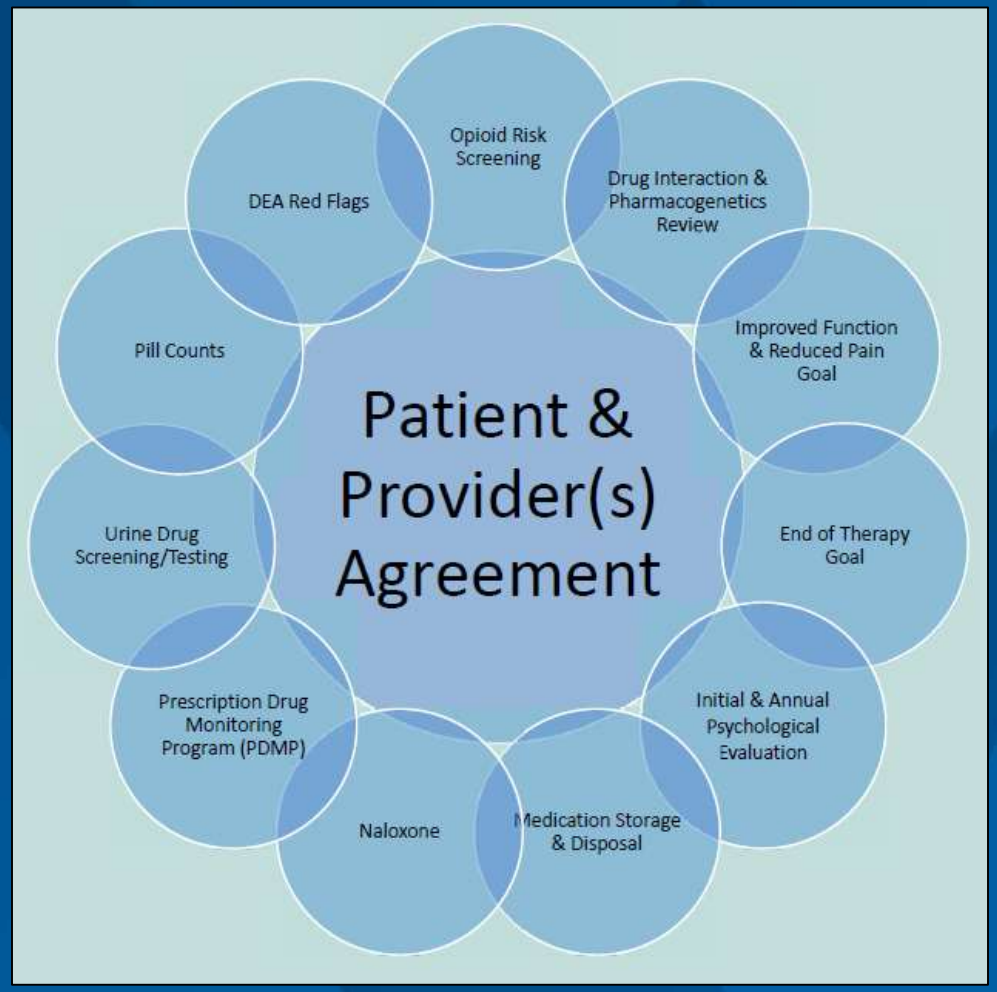
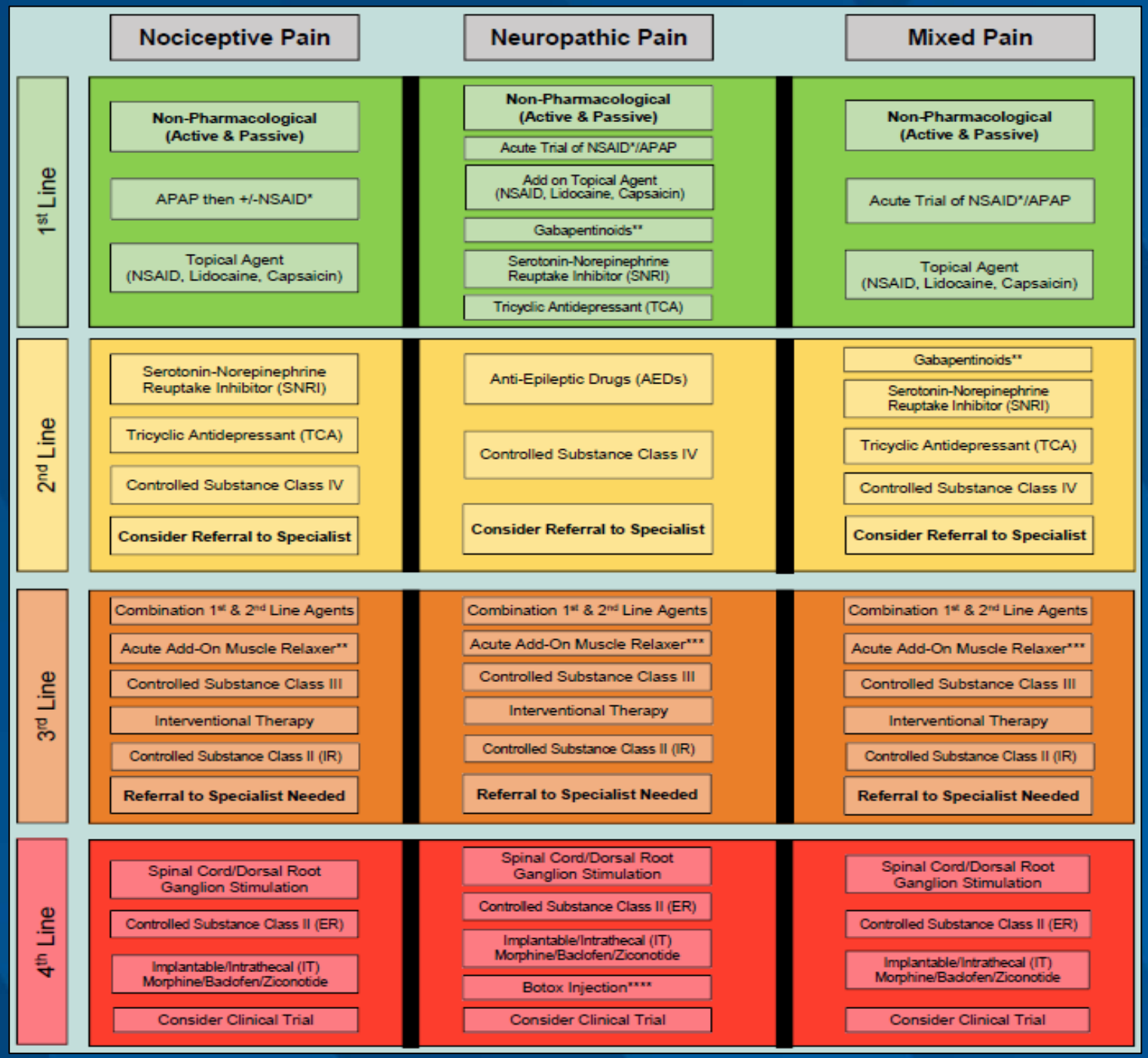
Risk Reduction Strategy

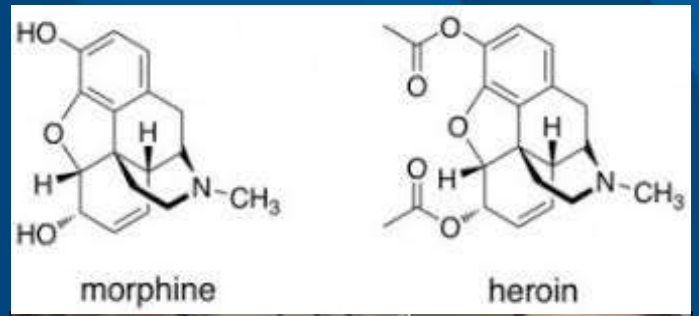




Clinical Treatment Algorithms

Opioid-Related Public Service Announcement

https://www.littlethings.com/psa-painkillers/

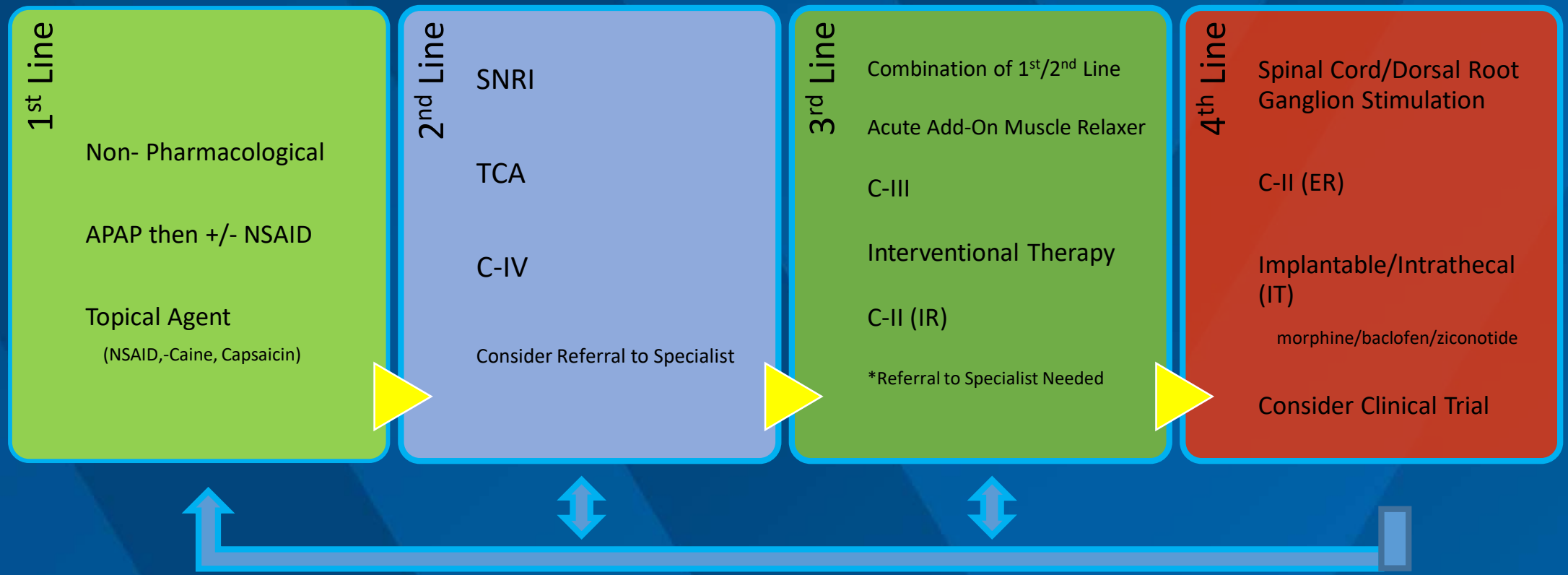


PSA Reminds Us Of The Harsh Possible Repercussions Of Using Prescription Painkillers

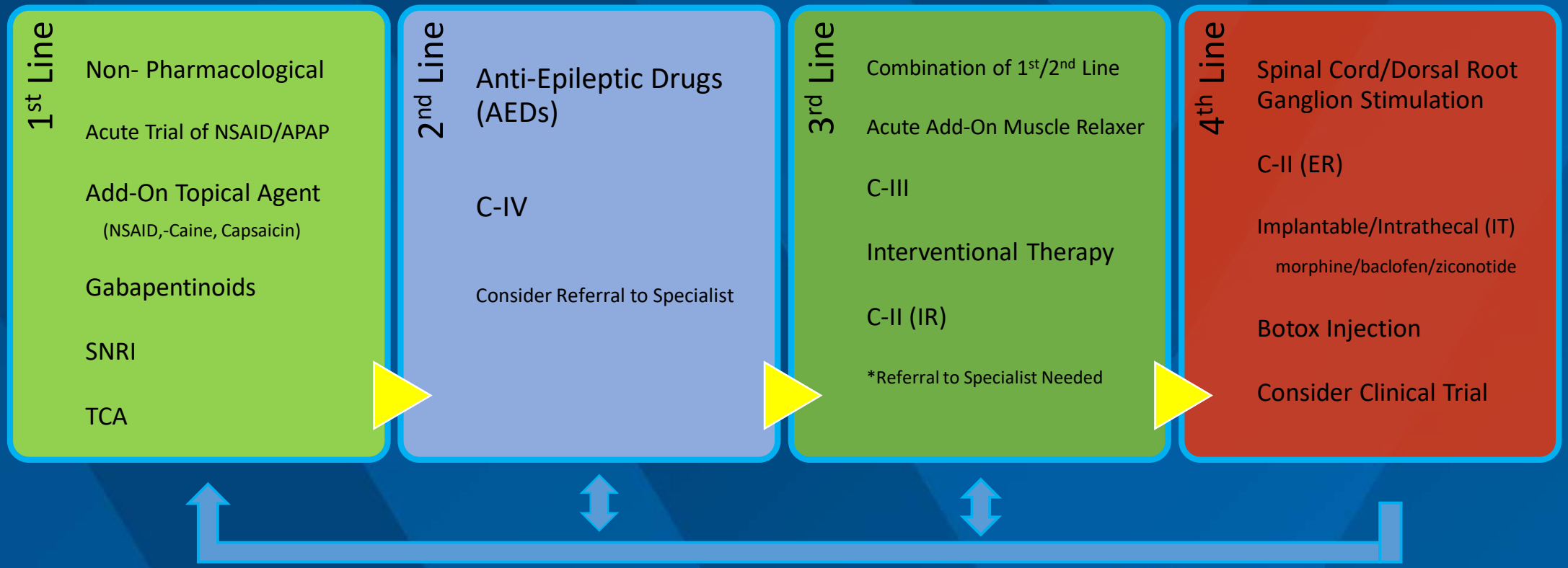
This is one of those videos that everyone should watch at least once. Health issues, prescriptions, and medical situations in general are too often handled without enough care....

LITTLETHINGS.COM

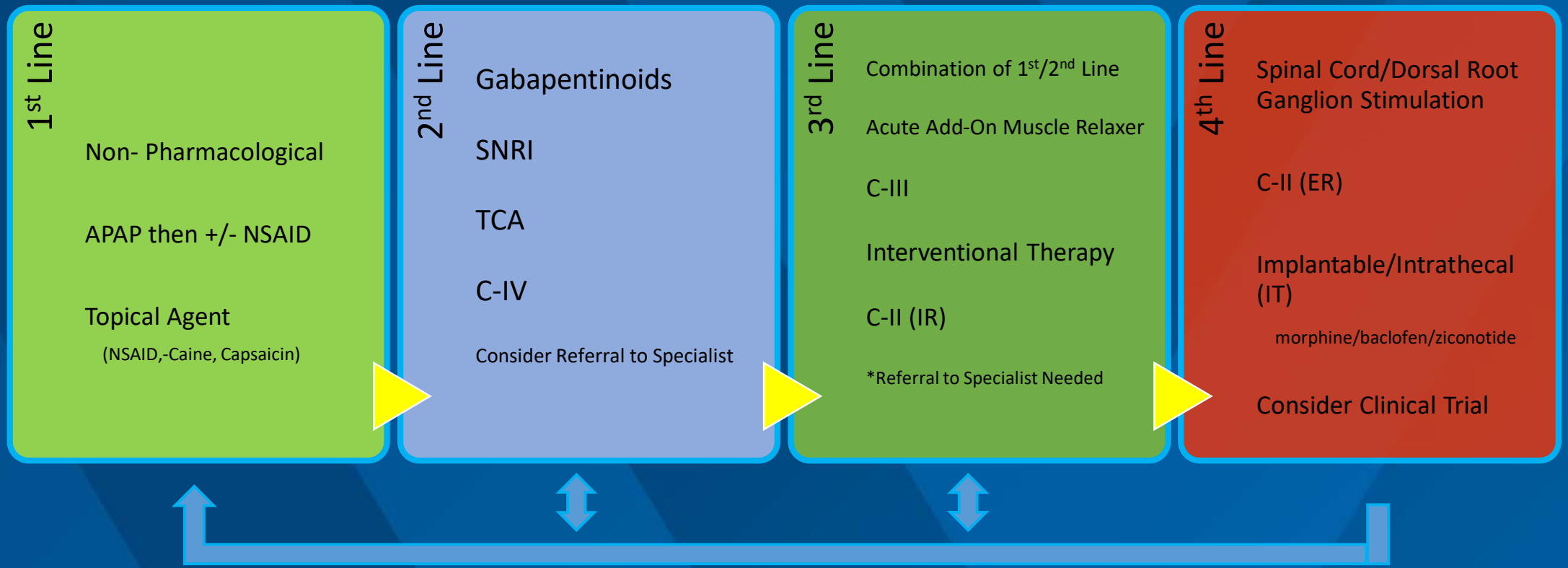
Nociceptive Pain
Clinical Treatment Algorithm



Neuropathic Pain
Clinical Treatment Algorithm



Mixed Pain
Clinical Treatment Algorithm



	Nociceptive Pain	Neuropathic Pain	Mixed Pain
1st Line	**Non-Pharmacological (Active & Passive)** APAP then +/-NSAID* Topical Agent (NSAID, Lidocaine, Capsaicin)	**Non-Pharmacological (Active & Passive)** Acute Trial of NSAID*/APAP Add on Topical Agent (NSAID, Lidocaine, Capsaicin) Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA)	**Non-Pharmacological (Active & Passive)** Acute Trial of NSAID*/APAP Topical Agent (NSAID, Lidocaine, Capsaicin)
2nd Line	Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**	Anti-Epileptic Drugs (AEDs) Controlled Substance Class IV **Consider Referral to Specialist**	Gabapentinoids** Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) Tricyclic Antidepressant (TCA) Controlled Substance Class IV **Consider Referral to Specialist**
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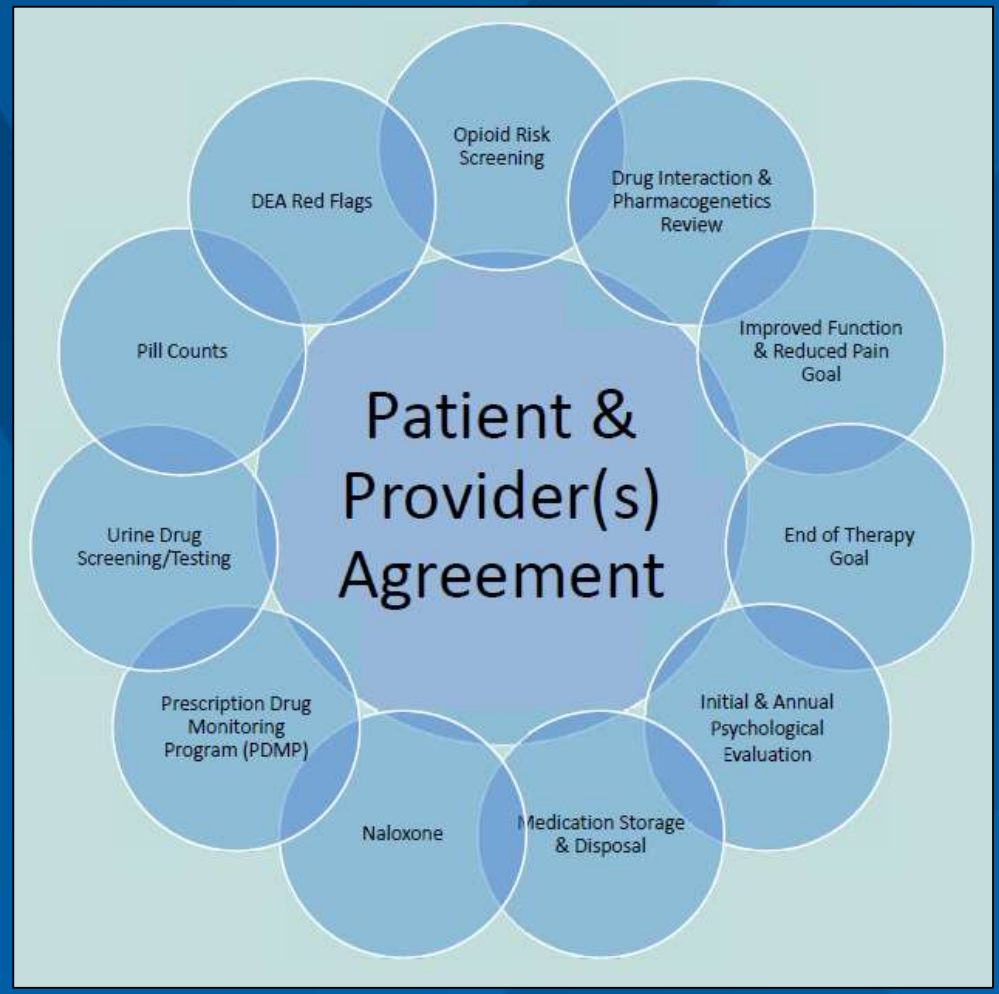

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