News and Information for West Virginia Providers from the West Virginia Bureau for Medical Services (WVBMS)

June 2016
Published Quarterly by Health Information Designs, LLC

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Topics Covered in This Issue

- 2016 CDC Guideline for Prescribing Opioids for Chronic Pain
  - Background
  - Recommendations
  - Translation and Implementation

Overview of the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain

Background

- 259 million prescriptions for opioid pain medication were written in 2012, enough for every adult American to have a bottle of pills
- 11.3% of Americans experience daily (chronic) pain
- As many as 1 in 4 patients receiving long-term opioid therapy in primary care settings struggle with opioid use disorder
- Greater than 165,000 prescription opioid-related overdose deaths since 1999
- Primary care clinicians:
  - Account for ~50% of opioid pain medications dispensed
  - Report concern about opioids and insufficient training
  - Feel pressured to treat with opioids
  - Are concerned about secondary gain/diversion and “abusive” or “difficult” patients
- Purpose of guidelines is to improve knowledge, provide clarity on recommendations, and change prescribing practices to benefit health of patient

CDC Recommendations

Determining when to initiate or continue opioids for chronic pain

- Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain (i.e., lasting > 3 months or past time of normal tissue healing).
  - Consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks.

  - If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.
    - Non-pharmacologic therapy (i.e., exercise therapy and cognitive behavior therapy) to reduce pain and improve function
    - Non-opioid pharmacologic therapy (i.e., NSAIDs, acetaminophen, anticonvulsants, SNRIs) when benefits outweigh risks, combined with non-pharmacologic therapy
- Before starting opioid therapy for chronic pain:
  - Determine how effectiveness will be evaluated.
  - Establish treatment goals with all patients (pain relief and function).
  - Assess progress using three-item PEG Assessment Scale:
    - Pain average (0–10)
    - Interference with Enjoyment of life (0–10)
    - Interference with General activity (0–10)
  - Continue only if there is clinically meaningful improvement in pain and function.
    - 30% = clinically meaningful improvement.
  - Consider how to discontinue therapy if benefits do not outweigh risks.
- Before starting and periodically during opioid therapy, clinicians should discuss with patients the known risks and realistic benefits of opioid therapy and the patient and clinician responsibilities for managing therapy.
  - Be explicit and realistic about expected benefits.
  - Emphasize improvement in function as a primary goal.
  - Discuss:
    - Serious and common adverse effects
    - Increased risks of overdose:
      - At higher dosages
      - When opioids are taken with other drugs or alcohol
    - Periodic reassessment, Prescription Drug Monitoring Program (PDMP), and Urine Drug Testing (UDT) checks
    - Risks to family members and individuals in the community

Opioid selection, dosage, duration, follow-up, and discontinuation

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- When opioids are started, clinicians should:
  - Start at lowest effective dosage
  - Increase dosage by smallest practical amount
  - It total opioid dosage is greater than or equal to (≥) 50 Morphine Milligram Equivalents (MME)/day:
    - Reassess pain, function, and treatment
    - Increase frequency of follow-up
    - Consider offering naloxone

  - Avoid increasing opioid dosages greater than or equal to (≥) 90 MME/day
  - If escalating dosage requirements:
    - Discuss other pain therapies with the patient
    - Consider working with patient to taper opioids down or off
    - Consider consulting a pain specialist
- Long-term opioid use often begins with treatment of acute pain.
  - Prescribe the lowest effective dose
  - Prescribe the amount to match the expected duration of pain severe enough to require opioids
  - Often less than or equal to (≤) three days and rarely more than seven days are needed
  - Do not prescribe additional opioids "just in case"
  - Re-evaluate patients with severe acute pain that continues longer than expected to confirm or revise the initial diagnosis and adjust management
  - Do not prescribe ER/LA opioids for acute pain
- Clinicians should evaluate benefits and harms with patient within one to four weeks of starting opioid therapy for chronic pain or of dose escalation.
  - Evaluate at least every three months or more frequently
  - At follow-up, determine whether:
    - Opioids continue to meet treatment goals
    - There are common or serious adverse events or early warning signs
    - Benefits of opioids continue to outweigh risks
    - Opioid dosage can be reduced or opioids can be discontinued
  - Offer to work with patients to taper opioids down or off when:
    - No sustained clinically meaningful improvement in pain and function
    - Opioid dosages greater than or equal to (≥) 50 MME/day without evidence of benefit
    - Concurrent benzodiazepines that cannot be tapered off
    - Patients request dosage reduction or discontinuation
    - Patients experience overdose, other serious events, or warning signs
  - Taper slowly enough to minimize opioid withdrawal
    - Decrease of 10% per week is a reasonable starting point
  - Optimize non-opioid pain management and psychosocial support

Assessing risk and addressing harms of opioid use

- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
  - Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible
  - Carefully weigh risks and benefits with pregnant patients
  - Use additional caution with renal or hepatic insufficiency in patients aged 65 years or older
  - Ensure treatment for depression is optimized
  - Consider offering naloxone when patients:

    - Have a history of overdose
    - Have a history of substance use disorder
    - Are taking central nervous system depressants with opioids
    - Are on higher dosages of opioids (≥ 50 MME/day)
- Review patient's history of controlled substances using state Prescription Drug Monitoring Program (PDMP)
  - Review data when initiating opioid therapy for chronic pain and periodically during therapy, ranging from every prescription to every three months
  - If prescriptions from multiple sources, high dosages, or dangerous combinations:
    - Discuss safety concerns and increased risk of overdose with patient
    - For patients receiving high total opioid dosages, consider tapering to a safer dosage, consider offering naloxone
    - Discuss safety concerns with others prescribing to your patient
    - Consider opioid use disorder and discuss concerns with your patient
    - If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing (UDT) to assist in determining whether opioids can be discontinued without causing withdrawal
    - Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions
- 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.
- Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
  - Taper benzodiazepines gradually
  - Offer evidence-based psychotherapies for anxiety:
    - Cognitive behavioral therapy (CBT)
    - Specific antidepressants approved for anxiety
    - Other non-benzodiazepine medications approved for anxiety
  - Coordinate care with mental health professionals
- 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.
  - Provide opportunity for patient to disclose concerns
  - Assess for Opioid Use Disorder (OUD) using DSM-5 criteria; if present, offer or arrange Medication Assisted Treatment (MAT)

Translation and implementation

- Website:
  - http://www.cdc.gov/drugoverdose/prescribing/guideline.html
  - http://www.cdc.gov/drugoverdose/prescribing/resources.html
- Checklist/algorithm:
  - http://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

- Mobile application (including MME calculator)
- Fact sheets:
  - Assessing benefit and harm: http://www.cdc.gov/drugoverdose/pdf/assessing_benefits_harms_of_opioid_therapy-a.pdf
  - MME conversions
  - Non-pharmacologic and non-opioid pharmacologic therapy options: http://www.cdc.gov/drugoverdose/pdf/alternative_treatments-a.pdf
  - Checking the Prescription Drug Monitoring Program: http://www.cdc.gov/drugoverdose/pdf/pdmp_factsheet-a.pdf
- Poster:
  - http://www.cdc.gov/drugoverdose/pdf/guidelines_patients_poster-a.pdf

Summary

- Opioid use decision:
  - Non-pharmacologic, non-opioid pharmacologic, then opioid
  - Establish realistic goals of therapy
  - Discuss risks and side effects
- Opioid selection:
  - Immediate Release (IR), not Extended Release (ER)
  - MME greater than or equal to (≥) 50 use caution, avoid MME greater than or equal to (≥) 90
  - Acute pain usually less than three days, up to seven days
  - Evaluate after one month, then every three months
- Assessing risks:
  - Higher risks, consider naloxone
  - Review PDMP initially and at least every three months
  - Urine drug screening initially and at least annually
  - Opioid use disorder (OUD), consider Medication Assisted Treatment (MAT)

References

1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. Recommendations and Reports 2016; 65(1): 1-49.
2. Codeine (2015), tapentadol (2014), morphine sulfate (2015), hydrocodone bitartrate (2015), oxymorphone hydrochloride (2014), hydromorphone hydrochloride (2015), fentanyl (2015), methadone hydrochloride (2015), oxycodone hydrochloride (2015). In: Drug Facts and Comparisons (Facts and Comparisons eAnswers). St. Louis: Wolters Kluwer Health. Available athttp://online.factsandcomparisons.com/index.aspx.
3. Codeine phosphate (2016), tapentadol hydrochloride (2016) morphine sulfate (2016), hydrocodone bitatrate (2016), oxycodone (2016), oxymorphone hydrochloride (2016), hydromorphone hydrochloride (2016), fentanyl (2016), methadone (2016). In: Micromedex® Healthcare Series. Version 5.1. Greenwood Village, CO: Thomson Micromedex. Available at http://www.micromedexsolutions.com/micromedex2/librarian/ND_T/evidencexpert/ND_PR/evidencexpert/CS/F7F0A8/ND_AppProduct/evidencexpert/DUPLICATIONSHIELDSYNC/27DAB5/ND_PG/evidencexpert/ND_B/evidencexpert/ND_P/evidencexpert/PFActionId/pf.HomePage?navitem=topHome&isToolPage=true.
4. Centers for Disease Control and Prevention. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov.
5. Gupta S, Atcheson R. Opioid and chronic non-cancer pain. Journal of Anesthesiology Clinical Pharmacology 2013: 29(1); 6-12.

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