Draft Guidelines for Opioid Prescribing

**Scope and purpose of the guideline**: To help providers make informed decisions about acute and chronic pain treatment for adult patients. The recommendations focus on the use of opioids in treating chronic pain—pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing.

1) **Use non-opioid therapies**
   Use non-pharmacologic therapies (such as exercise and cognitive behavioral therapy) and non-opioid pharmacologic therapies (such as anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

2) **Start low and go slow**
   When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

3) **Follow-up**
   Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

**What’s included in the guideline?**
The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

1) **Determining when to initiate or continue opioids for chronic pain**
   - Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
   - Establishment of treatment goals
   - Discussion of risks and benefits of therapy with patients

2) **Opioid selection, dosage, duration, follow-up and discontinuation**
   - Selection of immediate-release or extended-release and long-acting opioids
   - Dosage considerations
   - Duration of treatment
   - Considerations for follow-up and discontinuation of opioid therapy

3) **Assessing risk and addressing harms of opioid use**
   - Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
   - Review of prescription drug monitoring program (PDMP) data
   - Use of urine drug testing
   - Considerations for co-prescribing benzodiazepines
   - Arrangement of treatment for opioid use disorder
State of Wisconsin Opioid Guideline

1. A practitioner’s first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.
   a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of a clear clinical rationale should be present.
   b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.
   c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

2. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:
   a. Medical history and physical examination targeted to the pain condition
   b. Nature and intensity of the pain
   c. Current and past treatments, with response to each treatment
   d. Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, COPD, etc.)
   e. Effect of pain on physical and psychological functioning
   f. Personal and family history of substance abuse
   g. History of psychiatric disorders associated with opioid abuse (bipolar, ADD/ADHD, sociopathic, borderline, untreated/severe depression)
   h. Medical indication(s) for use of opioids

3. Opioids should not be the first choice in treating acute or chronic pain.
   a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, nonsteroidal anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid therapy, although opioids could be simultaneously prescribed if it is apparent from the patient’s condition that he/she will need opioids in addition to these.
   b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.
   c. Chronic pain: Evidence for opioids is poor. Multiple meta-analyses demonstrate that the benefits are slight, while annualized mortality rates are dramatically increased. There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate justification on the chart to indicate why chronic opioid therapy was chosen in a given patient. Note: There is no high-quality evidence to support opioid therapy longer than 6 months in duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to the release of these Guidelines and have demonstrated no evidence of aberrant behavior.
   d. Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.
4. Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If, after a reasonable trial, these goals are not met, opioids should be weaned or discontinued. Visual analog scales, 0-10 scales, and smiling/frowning faces are good measures of pain levels. Instruments for assessing function include but are not limited to: 1) The Oswestry Disability Index, 2) The Brief Pain Inventory, 3) The SF-12, 4) For fibromyalgia patients, the Fibromyalgia Impact Questionnaire.

5. Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy, and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued and the patient should be treated for withdrawal, if needed.

   a. Exceptions to this include patients with unstable angina (withdrawal could precipitate a myocardial infarction) and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).

   b. Components of ongoing assessment of risk include:
      i. Review of the Prescription Drug Monitoring Program (PDMP) information
      ii. Periodic urine drug testing – at least yearly in low risk cases, more frequently if evidence of increased risk (including chromatography is strongly recommended)
      iii. Periodic pill counts – at least yearly and low risk cases, more frequently if evidence of increased risk
      iv. Violations of the opioid agreement

6. All patients on chronic opioid therapy should have informed consent consisting of:

   a. Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death

   b. Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects

7. Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.

8. Opioids should be prescribed in the lowest effective dose. If daily doses for chronic pain reach 50 morphine equivalent mgs. (MEMs), additional precautions should be implemented (see #5.b. above). Given that there is no evidence base to support efficacy of doses over 90 MEMs, with dramatically increased risks, dosing above this level is strongly discouraged, and clear and compelling documentation to support such dosing should be present on the chart.

9. The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should be considered an opioid of last resort and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

10. Prescribing of opioids is very strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be documented in the chart.
11. In treating acute pain, the lowest dose and lowest number of pills needed should be prescribed. In most cases, less than 3 days’ worth are necessary, and rarely more than 7 days’ worth. Untaken pills in medicine cabinets are the primary source for illicit opioid abuse in teens and young adults.

12. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

13. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:
   a. History of overdose (a relative contraindication to chronic opioid therapy)
   b. Opioid doses over 50 MEMs/day
   c. Clinical depression
   d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient, and Wisconsin prescribers can leave standing orders for this without a prescription at pharmacies in Wisconsin.

14. Prescribing of opioids is strongly discouraged in patients concurrently taking benzodiazepines or other respiratory depressants (barbiturates, carisoprodol, sedative-hypnotics, etc.). Benzodiazepines triple the already extremely high increases in annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

15. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner should be able to assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an addiction treatment center which is willing to accept the patient. Simply discharging a patient from the provider’s practice is not considered an acceptable alternative.