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ER/LA OPIOID REMS:

Achieving Safe Use While Improving Patient Care in the Emergency Department

Presented by CO*RE
Collaboration for REMS Education
www.core-rems.org

Collaborative for REMS Education

Faculty Information

Bio:
Dr. Michael Wahl

- Practices Emergency Medicine at North Shore University Health Systems (2004 – Present)
- Medical Director of the Illinois Poison Center, the oldest and one of the largest poison centers in the US
- Works with government relations and public health partners to advocate and create actions and plans to prevent injuries from emerging drugs of abuse or harmful products in communities.

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Disclosure to Learners

ER/LA Opioid REMS: Achieving Safe Use While Improving Patient Care in the Emergency Department

4/30/2015

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Slide 1

1 Stephen Anderson, 12/22/2014

CO*RE: Collaborative for REMS Education

On July 9, 2012, the Food and Drug Administration (FDA) approved a Risk Evaluation and Mitigation Strategy (REMS) for extended-release (ER) and long-acting (LA) opioid medications.

Founded in June, 2010, the Collaborative on REMS Education (CO*RE), a multi disciplinary team of 10 partners and 3 cooperating organizations, has designed a core curriculum based on needs assessment, practice gaps, clinical competencies, and learner self-assessment to meet the requirements of the FDA REMS Blueprint.

* Further tailoring of presentation by ACEP to maximize relevance

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CO*RE Organizations

Founding Partners

- American Pain Society (APS)
- American Academy of Hospice and Palliative Medicine (AAHPM)
- American Association of Nurse Practitioners (AANP)
- American Academy of Physician Assistants (AAPA)
- American Osteopathic Association (AOA)
- American Society of Addiction Medicine (ASAM)
- California Academy of Family Physicians (CAFP)
- Healthcare Performance Consulting (HPC)
- Interstate Postgraduate Medical Association (IPMA)
- Nurse Practitioner Healthcare Foundation (NPHF)

Strategic Partners

- Physicians Institute for Excellence in Medicine which coordinates 15 state medical societies
- Medscape
- American Academy of Family Physicians
- American College of Emergency Physicians (***New in 2015***)

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Content Development/Planner/Reviewer/Staff Disclosures

The following individuals disclose no relevant financial relationships:

Stephen H. Anderson MD, FACEP	ACEP Board Liaison to National Association of Pharmacy Board stakeholders task force on Opiate Abuse/ Overdose Death Epidemic
Rami Khoury MD, FACEP	Assistant Medical Director of Emergency Care at Allegiance Health, CO*RE Faculty , Clinical Assistant Professor at MSU College of Osteopathic Medicine
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Cynthia Singh, MS	Director of Grant and Foundation Development , Emergency Medicine Foundation
Michael Wahl, MD	Director/Medical Director Illinois Poison Center, Senior Clinical Educator, University of Chicago

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This educational activity is supported by an independent educational grant from the ER/LA Opioid Analgesics REMS Program Companies. Please see http://ce.er-la-opioidREMS.com/lwgCEUI/rems/pdf/List_of_RPC_Companies.pdf for a listing of the member companies. Funding for this education was mandated by the FDA.

This activity is intended to be fully compliant with the ER/LA Opioid Analgesics REMS education requirements issued by the U.S. Food & Drug Administration.

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Products Covered by this REMS

Brand Name Products	Generic Products
• Avinza® morphine sulfate ER capsules • Butrans® buprenorphine transdermal system • Dolophine® methadone hydrochloride tablets • Duragesic® fentanyl transdermal system • *Embeda® morphine sulfate/naltrexone ER capsules • Exalgo® hydromorphone hydrochloride ER tablets • Kadian® morphine sulfate ER capsules • Methadose™ methadone hydrochloride tablets • MS Contin® morphine sulfate CR tablets • Nucynta® ER tapentadol ER tablets • Opana® ER oxymorphone hydrochloride ER tablets • OxyContin® oxycodone hydrochloride CR tablets • †Palladone® hydromorphone hydrochloride ER capsules • Targiniq™ oxycodone hydrochloride/naloxone hydrochloride ER tablets • Zohydro® hydrocodone bitartrate ER capsules	• Fentanyl ER transdermal systems • Methadone hydrochloride tablets • Methadone hydrochloride oral concentrate • Methadone hydrochloride oral solution • Morphine sulfate ER tablets • Morphine sulfate ER capsules • Oxycodone hydrochloride ER tablets

* Not currently available due to voluntary recall (still approved); † No longer marketed (still approved)

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WHY PRESCRIBER EDUCATION IS IMPORTANT

Introduction

Prescribers of ER/LA Opioids Should Balance:

The benefits of prescribing ER/LA opioids to treat pain

The risks of serious adverse outcomes

ER/LA opioid analgesics should be prescribed only by health care professionals who are knowledgeable in the use of potent opioids for the management of pain

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Opioid Misuse/Abuse is a Major Public Health Problem

Improper use of any opioid can result in serious AEs including overdose & death

This risk can be greater w/ ER/LA opioids

ER opioid dosage units contain more opioid than IR formulations	*Methadone is a potent opioid with a long, highly variable half-life*
In 2012	**In 2011**
37 million Americans age ≥12 had used an opioid for nonmedical use some time in their life	488,004 ED visits involved nonmedical use of opioids • *Methadone involved in 30% of prescription opioid deaths*

SAMHSA. (2013). *Results from the 2012 National Survey on Drug Use and Health: Detailed Tables.* NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD. SAMHSA. (2013). *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits.* HHS Publication No. (SMA) 13-4760, DAWN Series D-39. Rockville, MD. CDC. CDC Vital Signs. *Prescription Painkiller Overdoses. Use and abuse of methadone as a painkiller.* 2012. FDA. Questions and Answers: FDA approves a Risk Evaluation and Mitigation Strategy for Extended-Release and Long-Acting Opioid Analgesics. www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm309742.htm. 2012.

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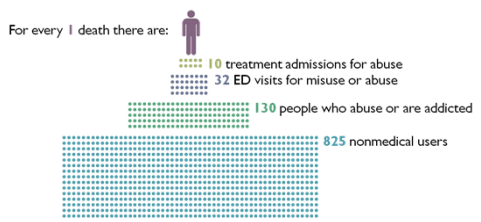
In 2011

41,340 Americans

DIED FROM DRUG POISONINGS

Nearly 17,000 deaths involved prescription opioids



Kochanek KD, et al. *National Vital Statistics Report* 2011;60:1-117. CDC Vital Signs. *Prescription Painkiller Overdoses. Use and abuse of methadone as a painkiller.* 2012. Warner M, et al. *Drug poisoning deaths in the United States, 1980-2008.* NCHS data brief, no 81. Hyattsville, MD: National Center for Health Statistics. 2011. National Center for Injury Prevention and Control. Division of Unintentional Injury Prevention. *Policy Impact: Prescription Painkiller Overdoses.* Nov 2011.

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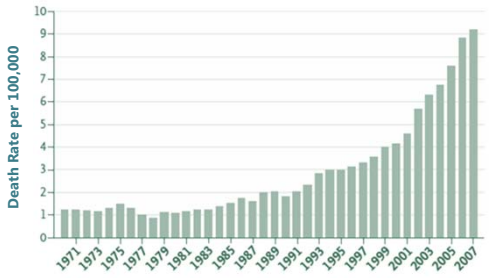
Okie, NEJM, Nov 2010

Deaths from Unintentional Drug Overdoses in the United States, 1970-2007



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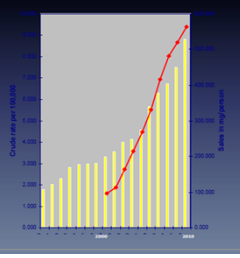
Overdose Death Rate correlates directly with Opioid sales (Prescription) rate

Unintentional drug overdose death rates & sales of Rx painkillers in US:



Source: National Vital Statistics System & Drug Enforcement Administration, ARCOS

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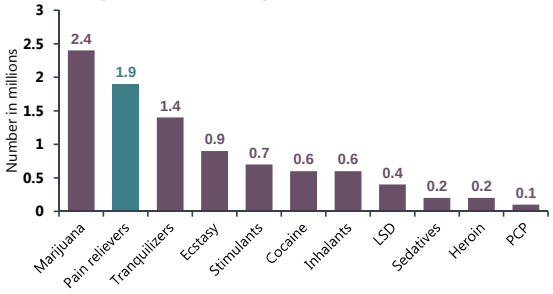
First-Time Use of Specific Drugs Among Persons Age ≥ 12 (2012)



SAMHSA. (2013). *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings.* NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD.

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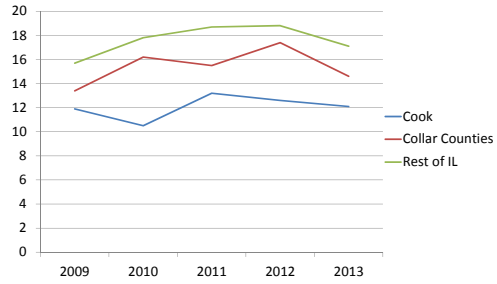
Geographic Variability in IL for presentation to hospital with prescription opioid abuse/overdose

County Area	2009	2010	2011	2012	2013
Cook	11.9	10.5	13.2	12.6	12.1
DuPage	11.7	15.7	15.7	16.4	13.6
Kane	14.4	13.6	13.0	13.0	9.9
Lake	11.9	14.9	13.9	19.9	16.6
McHenry	15.5	17.2	20.7	22.0	20.7
Will	15.6	19.6	16.5	17.6	14.8
Collar Counties	13.4	16.2	15.5	17.4	14.6
Rest of Illinois	15.7	17.8	18.7	18.8	17.1

Crude rate per 100,000 population based on IDPH Hospital Data

Non-Fatal Prescription Opioid OD



Suburban, Small Metro and rural communities have a higher rate of presenting to the Hospital for an OD (Population rate per 100,000)

Prescriptions Dispensed

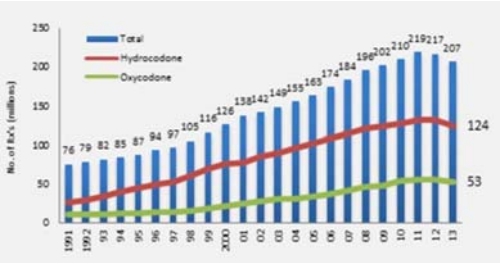


Figure 1 - Opioid Prescriptions Dispensed by US Retail Pharmacies IMS Health, Vector One: National, years 1991-1996, Data Extracted 2011. IMS Health, National Prescription Audit, years 1997-2013, Data Extracted 2014.

Squeezing the Balloon

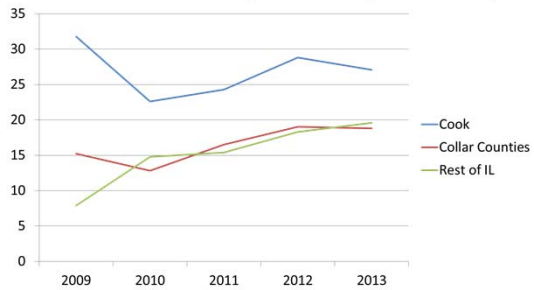
- Heroin is less expensive than pain medication
- CDC Estimates that 80% of new heroin users transitioned from Prescription Pain Medications
- So what is happening with heroin abuse?
- Where is its growth?

Geographic Variability in IL for presentation to hospital with Heroin abuse/overdose

County Area	2009	2010	2011	2012	2013
Cook	31.8	22.6	24.3	28.8	27.1
DuPage	15.2	13.6	15.2	19.2	18.3
Kane	14.7	9.3	11.8	13.0	13.4
Lake	16.2	16.5	19.3	19.1	17.2
McHenry	18.8	14.9	21.4	25.9	24.3
Will	12.8	9.7	16.7	20.1	22.9
Collar Counties	15.2	12.8	116.5	19.0	18.8
Rest of Illinois	7.9	14.8	15.4	18.3	19.6

Crude rate per 100,000 population based on IDPH Hospital Data

Non-fatal Heroin OD presenting to IL Hospitals



Increasing rate of Hospital visits for Heroin OD outside of the Metro Region per 100,000 population

Learning Objectives

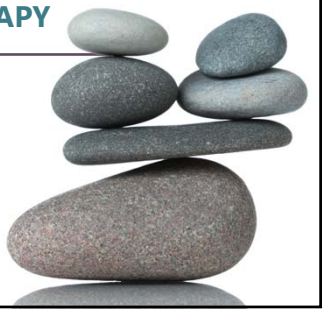
- Describe appropriate patient assessment for treatment with ER/LA opioid analgesics, evaluating risks and potential benefits of ER/LA therapy, as well as possible misuse.
- Apply proper methods to initiate therapy, modify dose, and discontinue use of ER/LA opioid analgesics, applying best practices including accurate dosing and conversion techniques, as well as appropriate discontinuation strategies.
- Demonstrate accurate knowledge about how to manage ongoing therapy with ER/LA opioid analgesics and properly use evidence-based tools while assessing for adverse effects.
- Employ methods to counsel patients and caregivers about the safe use of ER/LA opioid analgesics, including proper storage and disposal.
- Review/assess general and product-specific drug information concerning ER/LA opioid analgesics and identifying potential adverse effects of ER/LA opioids.

Misuse, abuse, divergence and overdose of ER/LA opioids is a major public health crisis in the Emergency Department .

YOU and **YOUR TEAM** ***can*** have an immediate and positive impact on this crisis while also caring for your patients appropriately.

ASSESSING PATIENTS FOR TREATMENT WITH ER/LA OPIOID ANALGESIC THERAPY

Unit 1



Balance Risks Against Potential Benefits in the Emergency Department

Conduct thorough H&P and appropriate testing as practical in the ED as practical in the ED

Benefits Include

- Analgesia (adequate pain control)
- Improved Function

Comprehensive benefit-to-harm evaluation

Risks Include

- Overdose
- Life-threatening respiratory depression
- Abuse by patient or household contacts
- Misuse & addiction
- Physical dependence & tolerance
- Interactions w/ other medications & substances
- Risk of neonatal withdrawal syndrome w/ prolonged use during pregnancy
- Inadvertent exposure/ingestion by household contacts, especially children

Chou R, et al. *J Pain.* 2009;10:113-30. Department of Veterans Affairs, Department of Defense. *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.* 2010.
FDA. *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics* Modified 08/2014. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM312290.pdf

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Adequately **DOCUMENT** all patient interactions, assessments, test results, & treatment plans

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Clinical Interview: Patient Medical History

Illness relevant to (1) effects or (2) metabolism of opioids

1. Pulmonary disease, constipation, nausea, cognitive impairment
2. Hepatic, renal disease

Illness possibly linked to substance abuse, e.g.:

Hepatitis	**HIV**	**Tuberculosis**	**Cellulitis**
STIs	**Trauma, burns**	**Cardiac disease**	**Pulmonary disease**

Chou R, et al. *J Pain.* 2009;10:113-30. Zacharoff KL, et al. *Managing Chronic Pain with Opioids in Primary Care.* 2nd ed. Newton, MA: Inflexion, Inc., 2010. Department of Veterans Affairs, Department of Defense. *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.* 2010.

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Clinical Interview: Pain & Treatment History

Description of pain

What relieves the pain?

What causes or increases pain?

Effects of pain on physical, emotional, and psychosocial function

Patient's pain & functional goals

Heapy A, Kerns RD. Psychological and Behavioral Assessment. In: Raj's Practical Management of Pain, 4th ed. 2008:279-95. Zacharoff KL, et al. Managing Chronic Pain with Opioids in Primary Care. 2nd ed. Newton, MA: Inflexion, Inc., 2010.

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Clinical Interview: Pain & Treatment History, cont'd

Pain Medications

Past use

Current use

Query state PDMP where available to confirm patient report
- Contact past providers & obtain prior medical records
- Conduct **UDT**

Dosage
- For opioids currently prescribed: opioid, dose, regimen, & duration
  - Important to determine if patient is **opioid tolerant**

General effectiveness

Nonpharmacologic strategies & effectiveness

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Perform Thorough Evaluation & Assessment of Pain

Seek objective confirmatory data

Components of patient evaluation for pain

Order diagnostic tests (appropriate to complaint)

General: vital signs, appearance, posture, gait, & pain behaviors

Neurologic exam

Musculoskeletal Exam
- Inspection
- Palpation
- Percussion
- Auscultation
- Provocative maneuvers

Cutaneous or trophic findings

Lalani I, Argoff CE. History and Physical Examination of the Pain Patient. In: *Raj's Practical Management of Pain*. 4th ed. 2008;177-88. Chou R, et al. *J Pain*. 2009;10:113-30.

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Assess Risk of Abuse, Including Substance Use & Psychiatric Hx: As Practical in Emergency Setting

Obtain a complete Hx of current & past substance use

- Prescription drugs
- Illegal substances
- Alcohol & tobacco
  - Substance abuse Hx does not prohibit treatment w/ ER/LA opioids but may require additional monitoring & expert consultation/referral
- Family Hx of substance abuse & psychiatric disorders
- Hx of sexual abuse

Social history also relevant

Employment, cultural background, social network, marital history, legal history, & other behavioral patterns

Risk Assessment, cont'd

Be knowledgeable about risk factors for opioid abuse	Understand & use addiction or abuse screening tools	Conduct a Urine Drug Test
• Personal or family Hx of alcohol or drug abuse • Younger age • Presence of psychiatric conditions	• Assess potential risks associated w/ chronic opioid therapy • Manage patients using ER/LA opioids based on risk assessment	• Understand limitations

Risk Assessment Tools: Examples

Tool	# of items	Administered By
Patients considered for long-term opioid therapy:		
ORT Opioid Risk Tool	5	patient
SOAPP® Screener & Opioid Assessment for Patients w/ Pain	24, 14, & 5	patient
DIRE Diagnosis, Intractability, Risk, & Efficacy Score	7	clinician
Characterize misuse once opioid treatments begins:		
PMQ Pain Medication Questionnaire	26	patient
COMM Current Opioid Misuse Measure	17	patient
PDUQ Prescription Drug Use Questionnaire	40	clinician
Not specific to pain populations:		
CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs	4	clinician
RAFFT Relax, Alone, Friends, Family, Trouble	5	patient
DAST Drug Abuse Screening Test	28	patient
SBIRT Screening, Brief Intervention, & Referral to Treatment	Varies	clinician

Opioid Risk Tool (ORT)

Mark each box that applies	Female	Male
1. Family Hx of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal Hx of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Age between 16 & 45 yrs	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring Totals:		

Administer

On initial visit

Prior to opioid therapy

Scoring *(risk)*

0-3: low

4-7: moderate

≥8: high

Webster LR, Webster RM. *Pain Med.* 2005;6:432-42.

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Screener & Opioid Assessment for Patients with Pain (SOAPP)®

Identifies patients as at high, moderate, or low risk for misuse of opioids prescribed for chronic pain

How is SOAPP® administered?

Usually self-administered in waiting room, exam room, or prior to an office visit

May be completed as part of an interview w/ a nurse, physician, or psychologist

Prescribers should have a completed & scored SOAPP® while making opioid treatment decisions

SOAPP® Monitoring Recommendations. https://painedu.org/soapp/SOAPP_Monitoring_Recommendations.pdf
The SOAPP® Version 1.0 Tutorial. https://painedu.org/soapp-tutorial_01.asp

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Optional Slide

SOAPP® : Available in 4 Formats to Assess Misuse Risk

SOAPP® 1.0 24Q version (original)	14Q version	5Q (short-form) version	SOAPP-R 24Q version (revised)
24 questions (14 used to score tool)	14 questions*	5 questions*	24 questions
Add ratings for 14 "screening" questions	Add ratings for each question		
Score ≥12: high risk 8-11: moderate risk <8: low risk	Score ≥12: high risk 8-11: moderate risk <8: low risk	Score ≥4: increased risk	Score ≥22: high risk 10-21: moderate risk ≤9: low risk
<10 min. to complete 10 "unscored" questions provide background	<8 min. to complete	<5 min. to complete	<10 min. to complete

*Questions from SOAPP V.1.0 Patients rate all questions on scale of 0-4

SOAPP® Monitoring Recommendations. painedu.org/soapp/SOAPP_Monitoring_Recommendations.pdf. *The SOAPP® Version 1.0 Tutorial.* painedu.org/soapp-tutorial_01.asp. *SOAPP® Frequently Asked Questions.* painedu.org/soapp-development.asp painedu.org. *SOAPP® Version 1.0-SF.* painedu.org. *SOAPP® Version 1.0-24Q.* painedu.org. *SOAPP®-R.* painedu.org

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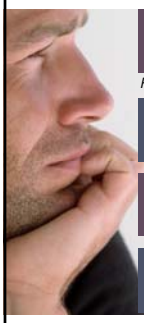
When to Consider a Trial of an Opioid



Potential benefits are likely to outweigh risks

Failed to adequately respond to nonopioid & nondrug interventions

Continuous, around-the-clock opioid analgesic is needed for an extended period of time

Pain is chronic and severe

No alternative therapy is likely to pose as favorable a balance of benefits to harms

Chou R, et al. *J Pain.* 2009;10:113-30. Department of Veterans Affairs, Department of Defense. *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.* 2010.

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When to Consider a Trial of an Opioid, cont'd

60-yr-old w/ chronic disabling OA pain

- Nonopioid therapies not effective, IR opioids provided some relief but experienced end-of-dose failure
- No psychiatric/medical comorbidity or personal/family drug abuse Hx
  - High potential benefits relative to potential risks
  - Could prescribe opioids to this patient in most settings w/ routine monitoring

30-yr-old w/ fibromyalgia & recent IV drug abuse

- High potential risks relative to benefits (opioid therapy not 1st line for fibromyalgia)
- Requires intensive structure, monitoring, & management by clinician w/ expertise in both addiction & pain
  - Not a good candidate for opioid therapy

Chou R, et al. *J Pain.* 2009;10:113-30.

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When to Consider Adding Additional Analgesia in a Trial of an Opioid, cont'd

Selection of patients between these 2 extremes requires:

Careful assessment & characterization of patient risk

Structuring of care to match risk

In patients w/ Hx of substance abuse or a psychiatric comorbidity, this may require assistance from experts in managing pain, addiction, or other mental health concerns

In some cases opioids may not be appropriate or should be deferred until the comorbidity has been adequately addressed

– Consider referral

Chou R, et al. *J Pain.* 2009;10:113-30.

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Referring High-Risk Patients

Prescribers should

- Understand when to appropriately refer high-risk patients to pain management or addiction specialists
- Also check your state regulations for requirements

Chou R, et al. *J Pain*. 2009;10:113-30.

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Special Considerations: Elderly Patients

Does patient have medical problems that increase risk of opioid-related AEs?

Respiratory depression more likely in elderly, cachectic, or debilitated patients

- Altered PK due to poor fat stores, muscle wasting, or altered clearance
- Monitor closely, particularly when
  - Initiating & titrating ER/LA opioids
  - Given concomitantly w/ other drugs that depress respiration
- Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients
- Titrate dose cautiously

Older adults more likely to develop constipation

- Routinely initiate a bowel regimen before it develops

Is patient/caregiver likely to manage opioid therapy responsibly?

American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons. *J Am Geriatr Soc*. 2009;57:1331-46. Chou R, et al. *J Pain*. 2009;10:113-30.

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Special Considerations: Pregnant Women

Managing chronic pain in pregnant women is challenging, & affects both mother and fetus

Potential risks of opioid therapy to the newborn include:

- Low birth weight
- Premature birth
- Hypoxic-ischemic brain injury
- Neonatal death
- Prolonged QT syndrome
- Neonatal opioid withdrawal syndrome

Given these potential risks, clinicians should:

- Counsel women of childbearing potential about risks & benefits of opioid therapy during pregnancy & after delivery
- Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks

If chronic opioid therapy is used during pregnancy, anticipate & manage risks to the patient and newborns

Chou R, et al. *J Pain*. 2009;10:113-30.

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Special Considerations: Children (<18 years)

Safety & effectiveness of most ER/LA opioids unestablished

* Pediatric analgesic trials pose challenges
  Transdermal fentanyl approved in children aged ≥2 yrs

Most opioid studies focus on inpatient safety

Opioids are common sources of drug error

Opioid indications are primarily life-limiting conditions

Few children with chronic pain due to non-life-limiting conditions should receive opioids

When prescribing opioids to children:

Consult pediatric palliative care team or pediatric pain specialist or refer to a specialized multidisciplinary pain clinic

Berde CB, et al. *Pediatrics.* 2012;129:354-64. Gregoire MC, et al. *Pain Res Manag* 2013;18:47-50. Mc Donnell C. *Pain Res Manag.* 2011;16:93-8. Slater ME, et al. *Pain Med.* 2010;11:207-14.

Optional Slide

Case:

Peter
25-Year-Old Male

Case:

Peter

Optional Slide

New to local area, presents at 6PM on Friday to your ED

- Chronic left knee pain from a MVA 5 yrs ago
- Wants oxycodone ER & oxycodone IR for "rescue"

Hx

- 3 knee surgeries—last was 18 mo ago
- Persistent ambulatory dysfunction—granted disability
- Prior therapies: medications, supporting devices, & PT
  - Only oxycodone ER works
    - Allergic to acetaminophen & NSAIDs
    - Morphine & codeine make him throw up
  - PT sessions not helpful

Physical examination of knee

- No erythema, swelling, or bruising; surgical scars present
- Left quadriceps has signs of atrophy compared to right side
- Limited ROM on flexion of left knee

Peter: Assess Abuse Risk w/ 5-Q SOAPP

Optional Slide

How often:	Never= 0	Seldom= 1	Sometimes= 2	Often= 3	Very often=4
1. Do you have mood swings?		☑			
2. Do you smoke a cigarette within an hr after you wake up?					☑
3. Have you taken medication other than the way that it was prescribed?	☑				
4. Have you used illegal drugs (e.g., marijuana, cocaine) in past 5 yrs?		☑			
5. In your lifetime, have you had legal problems or been arrested?		☑			

After further questioning:

- Admits smoking 1 cigarette pack/d for 10 yrs
- Claims occasional marijuana use, not for last 2 yrs

Total Score: 7

(Cutoff is 4)=high risk for prescription opioid misuse

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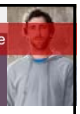
Peter: Assess Abuse Risk

Optional Slide



Ask for contact details of prior regular physician

- No info w/ him—can get it on Monday if you give him a prescription now

Ask Peter to provide a urine sample for testing

- He accuses you of not trusting him
- Explain it is your office policy for a new patient being considered for a controlled substance
  - He goes with your nurse

Access your state's PDMP: 6-month report

- Received 28 prescriptions from 4 physicians, using 5 pharmacies
  - Left quadriceps has signs of atrophy compared to right side
- Some paid for w/ insurance, others w/ cash

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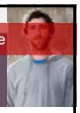
Peter: UDT & Results

Optional Slide



POC immunoassay cup tests for THC, cocaine, opiates, methamphetamine, & amphetamine

- Only detects naturally occurring opiates – morphine & codeine
- **Semisynthetic oxycodone not reliably detected**
  - Included in some, but not all panels – always check

POC test positive for THC & negative for other substances

Second sample sent to laboratory, w/ request for a pain management profile that includes oxycodone

- Adulterant panel, THC, cocaine, opiates, & oxycodone

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Peter: What Now? Should You:

Optional Slide

1. Write a 4-day supply of ER & IR oxycodone, to last until you contact his previous prescriber on Monday
2. Not write a prescription today, since he lied about prescribers & drug use. Untreated addiction prevents you from addressing his pain; refer to a pain management physician w/ addiction expertise
3. Write 30-day prescriptions for ER & IR oxycodone while you carry out diagnostic tests on his injury, obtain his prior medical records, & review test results

Answer 2 is correct

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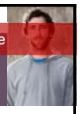
Peter: Case Summary

Optional Slide



Several red flags raised:

- PDMP report revealed probable doctor shopping
- UDT positive for recent marijuana use, which he denied
- SOAPP score suggests risk for prescription drug misuse
- DEA identified modus operandi used by a drug-seeking patient
  - Wants appointment toward end of office hrs
  - Requests specific controlled substance
  - Claims nonopioid analgesics do not work or allergy
  - Reluctant to give name of primary physician
- Younger age

Peter may have a pain problem:

- Beyond your scope of practice to manage while his addiction is untreated
- Refer to pain management or addiction specialist

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Challenge: The Friday Afternoon Patient

Optional Slide

Red Flag:

Adjusting a prescription without performing appropriate evaluation or screening

It is 6 pm on Friday and the waiting room is filling up. Mr. Kingston asks you to increase his current dosage of hydrocodone, because he says it is not relieving his pain. It would take you two minutes to say yes, and longer to say no.

Action: Check your local PDMP. Employ practice management strategies that maximize efficiency.

- Patient-administered screening tools
- Administer and score tools, document results, and communicate to the primary prescriber.

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Challenge: The Delayed Surgery

Optional Slide

Red Flag:

Patient may be stalling to continue an opioid regimen

Mr. Van Buskirk says she needs opioids to manage his hernia pain until he can have surgery. He reports continued delays in getting to surgery. You phone the surgeon and discover that no date has been set and that he has cancelled several appointments.

Action: Set expectations for time limitations. Offer non-medicine and non-opioid options for pain management. Consider referral to addiction specialist.

Pearls for Practice

- Document EVERYTHING
- Conduct a Comprehensive H&P
  - *General and pain-specific*
- Assess Risk of Abuse
- Compare Risks with Expected Benefits
- Determine whether appropriate additions or change in Tx is in order, in consultation with managing prescribers

INITIATING THERAPY, MODIFYING DOSING, & DISCONTINUING USE OF ER/LA OPIOID ANALGESICS

Unit II

Federal & State Regulations

Comply w/ federal & state laws & regulations that govern the use of opioid therapy for pain

Federal

- Code of Federal Regulations, Title 21 Section 1306: rules governing the issuance & filling of prescriptions pursuant to section 309 of the Act (21 USC 829)
  - www.deadiversion.usdoj.gov/21cfr/cfr/2106cfrt.htm
- United States Code (USC) - Controlled Substances Act, Title 21, Section 829: prescriptions
  - www.deadiversion.usdoj.gov/21cfr/21usc/829.htm

State

- Database of state statutes, regulations, & policies for pain management
  - www.medscape.com/resource/pain/opioid-policies
  - www.painpolicy.wisc.edu/database-statutes-regulations-other-policies-pain-management

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Initiating Treatment

Prescribers should regard initial treatment as a therapeutic trial

May last from several weeks to several months

Decision to proceed w/ long-term treatment should be intentional & based on careful consideration of outcomes during the trial

Progress toward meeting therapeutic goals	Presence of opioid-related AEs
Changes in underlying pain condition	Changes in psychiatric or medical comorbidities
Identification of aberrant drug-related behavior, addiction, or diversion	

Chou R, et al. *J Pain.* 2009;10:113-30

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Respiratory Depression

Chief hazard of opioid agonists, including ER/LA opioids

- If not immediately recognized & treated, may lead to respiratory arrest & death
- Greatest risk: initiation of therapy or after dose increase

Manifested by reduced urge to breathe & decreased respiration rate

- Shallow breathing
- CO_2 retention can exacerbate opioid sedating effects

Instruct patients/family members to call 911*

- Managed w/ close observation, supportive measures, & opioid antagonists, depending on patient's clinical status

Chou R, et al. *J Pain.* 2009;10:113-30. FDA. *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics.* 08/2014. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM311290.pdf

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ER/LA Opioid-Induced Respiratory Depression

More likely to occur	Reduce risk
• In elderly, cachectic, or debilitated patients – **Contraindicated** in patients w/ respiratory depression or conditions that increase risk • If given concomitantly w/ other drugs that depress respiration	• Proper dosing & titration are essential • **Do not overestimate** dose when converting dosage from another opioid product – Can result in fatal overdose w/ first dose • Instruct patients to swallow tablets/capsules whole – Dose from cut, crushed, dissolved, or chewed tablets/capsules may be fatal, particularly in opioid-naïve individuals

FDA. *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics.* 08/2014. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM311290.pdf

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Initiating & Titrating: Opioid-Naïve Patients

Drug & dose selection is critical	Monitor patients closely for respiratory depression	Individualize dosage by titration based on efficacy, tolerability, & presence of AEs
Some ER/LA opioids or dosage forms are only recommended for **opioid-tolerant** patients • ANY strength of transdermal fentanyl or hydromorphone ER • Certain strengths/doses of other ER/LA products (check drug PI)	Especially within 24-72 h of initiating therapy & increasing dosage	Check ER/LA opioid product PI for minimum titration intervals Supplement w/ IR analgesics (opioids & nonopioid) if pain is not controlled during titration

The ER/LA Opioid Analgesics Risk Evaluation & Mitigation Strategy: Educational Program Important Safety Information. Abuse potential & risk of life-threatening respiratory depression. www.er-la-opioidrems.com/Shared/Items/pdf/ImportantSafetyInformation.pdf. 2012. Chest R, et al. J Pain. 2009;10:131-149. FDA. *Blueprint for Prescriber Education for ER/LA Opioid Analgesics.* 08/2014. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM311290.pdf

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Initiating: Opioid-Tolerant Patients

If opioid tolerant –
no restrictions on which products can be used

Patients considered opioid tolerant are taking at least
- 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hr
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- An equianalgesic dose of another opioid

Still requires caution when rotating a patient on an IR opioid to a different ER/LA opioid

For 1 Wk Or Longer

The ER/LA Opioid Analgesics Risk Evaluation & Mitigation Strategy: Educational Program Important Safety Information. Abuse potential & risk of life-threatening respiratory depression. www.er-la-opioidrems.com/Shared/Items/pdf/ImportantSafetyInformation.pdf. 2012.

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Opioid Rotation

Definition:

Change from an existing opioid regimen to another opioid w/ the goal of improving therapeutic outcomes or to avoid AEs attributed to the existing drug, e.g., myoclonus

Rationale:

Differences in pharmacologic or other effects make it likely that a switch will improve outcomes

- Effectiveness & AEs of different mu opioids vary among patients
- Patients show incomplete cross-tolerance to new opioid
  - Patient tolerant to 1st opioid can have improved analgesia from 2nd opioid at a dose lower than calculated from an EDT

Fine PG, et al. *J Pain Symptom Manage.* 2009;38:418-25. Knotkova H, et al. *J Pain Symptom Manage.* 2009;38:426-39. Pasternak GW. *Neuropharmacol.* 2004;47(suppl 1):312-23.

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Mu Opioid Receptors & Incomplete Cross-Tolerance

Optional Slide

Mu opioids bind to mu receptors

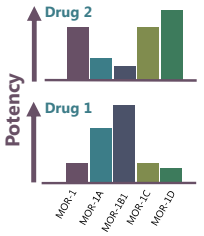
Many mu receptor subtypes:

Mu opioids produce **subtly different** pharmacologic response based on distinct activation profiles of mu receptor subtypes

May help explain:

Inter-patient variability in response to mu opioids

Incomplete cross-tolerance among mu opioids



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Opioid Rotation

**** This should never be done in the Emergency Department without consultation with primary prescriber.**

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Reasons for Opioid Rotation

Optional Slide

Poor opioid responsiveness:

- Dose titration yields intolerable / unmanageable AEs
- Poor analgesic efficacy despite dose titration

Other potential reasons:

- Patient desire or need to try a new formulation
- Cost or insurance issues
- Adherence issues
- Concern about abuse or diversion
- Change in clinical status requires an opioid w/ different Pharmacokinetics (PK)
- Problematic drug-drug interactions

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Equianalgesic Doses/ Morphine Equivalents

Opioid rotation requires calculation of an approximate equianalgesic dose

Equianalgesic dose is a construct derived from relative opioid potency estimates

- Potency refers to dose required to produce a given effect

Relative potency estimates

- Ratio of doses necessary to obtain roughly equivalent effects
- Calculate across drugs or routes of administration
- Relative analgesic potency is converted into an equianalgesic dose by applying the dose ratio to a standard

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Equianalgesic Dose Tables (EDT)

Many different versions:

- Published
- Online
- Online Interactive
- Smart-phone apps

Vary in terms of:

- Equianalgesic values
- Whether ranges are used
- **Which opioids are included:** May or may not include transdermal opioids, rapid-onset fentanyl, ER/LA opioids, or opioid agonist-antagonists

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Example of an EDT for Adults

	Equianalgesic Dose		Usual Starting Doses	
Drug	**SC/IV**	**PO**	**Parenteral**	**PO**
Morphine	10 mg	30 mg	2.5-5 mg SC/IV q3-4hr (◆1.25 – 2.5mg)	5-15 mg q3-4hr (IR or oral solution) (◆2.5-7.5 mg)
Oxycodone	NA	20 mg	NA	5-10 mg q3-4 (◆2.5 mg)
Hydrocodone	NA	30 mg	NA	5 mg q3-4h (◆2.5 mg)
Hydromorphone	1.5 mg	7.5 mg	0.2-0.6 mg SC/IV q2-3hr (◆0.2mg)	1-2 mg q3-4hr (◆0.5-1 mg)

Limitations of EDTs

Single-dose potency studies using a specific route, conducted in patients w/ limited opioid exposure

Did Not Consider

Chronic dosing	High opioid doses	* Other routes
Different pain types	Comorbidities or organ dysfunction	Gender, ethnicity, advanced age, or concomitant medications
Direction of switch from 1 opioid to another	Inter-patient variability in pharmacologic response to opioids	Incomplete cross-tolerance among mu opioids

Utilizing Equianalgesic Doses

Incomplete cross-tolerance & inter-patient variability require use of conservative dosing when converting from one opioid to another

Equianalgesic dose a starting point for opioid rotation

Intended as General Guide

- Calculated dose of new drug based on EDT must be reduced, then titrate the new opioid as needed
- Closely follow patients during periods of dose adjustments

Follow conversion instructions in individual ER/LA opioid PI, when provided

Guidelines for Opioid Rotation

Calculate equianalgesic dose of new opioid from EDT

Reduce calculated equianalgesic dose by 25%-75%*

Select % reduction based on clinical judgment

Closer to 50% reduction if patient is	Closer to 25% reduction if patient
• Receiving a relatively high dose of current opioid regimen • Elderly or medically frail	• Does not have these characteristics • Is switching to a different administration route of same drug

*75%-90% reduction for methadone

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Guidelines for Opioid Rotation, cont'd

If switching to **methadone:**

- Reduce calculated equianalgesic dose by **75%-90%**
- For patients on very high opioid doses (e.g., ≥1,000 mg morphine equivalents/d), be cautious converting to methadone ≥100 mg/d
  - Consider inpatient monitoring, including serial EKG monitoring

If switching to **transdermal:**

- **Fentanyl**, calculate dose conversion based on equianalgesic dose ratios included in the PI
- **Buprenorphine**, follow instructions in the PI

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Guidelines for Opioid Rotation, cont'd

If switching to **methadone:**

- Standard EDTs are less helpful in opioid rotation to methadone
- In opioid tolerant patients, methadone doses should not exceed 30-40 mg/day upon rotation.
  - Consider inpatient monitoring, including serial EKG monitoring
- In opioid-naïve patients, methadone should not be given as an initial drug

If switching to **transdermal:**

- **Fentanyl**, calculate dose conversion based on equianalgesic dose ratios included in the Package Insert (PI)
- **Buprenorphine**, follow instructions in the PI

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Guidelines for Opioid Rotation, cont'd

Have a strategy to frequently assess analgesia, AEs and withdrawal symptoms

Titrate new opioid dose to optimize outcomes & safety

Dose for breakthrough pain (BTP) ***using a short-acting, immediate release preparation*** is 5%-15% of total daily opioid dose, administered at an appropriate interval

If oral transmucosal fentanyl product is used for BTP, begin dosing lowest dose irrespective of baseline opioid dose

NEVER use ER/LA opioids for BTP

Guideline for Opioid Rotation Summary

Optional Slide

Values from EDT*	Patient opioid values	"Solve" for X	Automatically reduce dose
Value of Current Opioid / Value of New Opioid	24 Hr dose of Current Opioid / X Amount of New Opioid	Equinalgesic 24 Hr Dose of New Opioid	By 25% – 75%

Frequently assess initial response	Titrate dose of new opioid to optimize outcomes	Calculate supplemental rescue dose used for titration at 5%-15% of total daily dose‡

*If switching to transdermal fentanyl, use equianalgesic dose ratios provided in PI
† If switching to methadone, reduce dose by 75%-90%
‡ If oral transmucosal fentanyl used as rescue, begin at lowest dose irrespective of baseline opioid

Breakthrough Pain in Chronic Pain Patients

Patients on stable ATC opioids may experience BTP	Therapies	Consider adding
Disease progression or a new or unrelated pain	• Directed at cause of BTP or precipitating factors • Nonspecific symptomatic therapies to lessen impact of BTP	• PRN IR opioid trial based on analysis of benefit versus risk – Risk for aberrant drug-related behaviors – High-risk: only in conjunction w/ frequent monitoring & follow-up – Low-risk: w/ routine follow-up & monitoring • Nonopioid drug therapies • Nonpharmacologic treatments

Optional Slide

Case:

Wilma
73-Year-Old Female

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Case:

Optional Slide

Wilma

Advanced Colon Cancer

- w/ peritoneal & liver metastases

Presents on Saturday to ED to control escalating pain despite Oxycodone IR 5mg Q6° and 1 QHS.

- New prescription < 2 weeks

Emphasize her preconceived ideas.

FACT: She is <u>not</u> opioid tolerant.

How do we help Wilma?

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Optional Slide

Reassess Underlying Medical Condition

Reasons for Escalation/ Inadequate

Pain Control?

- Part of the Medical Screening Exam is to rule out Emergency Medical Condition

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Optional Slide

Reassess Underlying Medical Condition

No option for hydromorphone ER or transdermal fentanyl

Only for opioid-tolerant patients

Avoid morphine & methadone due to her resistance

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Optional Slide

Ongoing Medical Management of Chronic Cancer Pain – No EMC

Discussion with Primary Care Givers prior to any changes prescriptions

Rational / Considerations involved in changes

- Patient not opioid tolerant
- Age
- Baseline metabolic disease
- Pain Management

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Optional Slide

Rotation Options for Wilma

Values from EDT*	Patient opioid values	"Solve" for X	Automatically reduce dose
Value of Current Opioid / Value of New Opioid	24 Hr dose of Current Opioid / X Amount of New Opioid	Equinalgesic 24 Hr Dose of New Opioid	By 25% – 75%

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Optional Slide

Educating Wilma to Take ER/LAs Safely

Advise Wilma to call

- Tomorrow to check in
- Any time to let you know...
  - If her pain worsens
  - She needs >2 doses of BTP medication/d
  - She experiences AEs

Caution Wilma*

- Store securely to prevent accidental exposure or theft
  - May result in serious harm/death (especially children) & can be abused
- Do not share w/ others
- Swallow whole: do not crush, chew, or dissolve
- Do not consume alcohol or use prescription or OTC products w/ alcohol
- Take Patient Counseling Document to any doctor visits

* Go over the Patient Counseling Document

Reasons for Discontinuing ER/LA Opioids

No progress toward therapeutic goals

Intolerable & Unmanageable AEs

Pain level decreases in stable patients

Nonadherence or unsafe behavior

- 1 or 2 episodes of increasing dose without prescriber knowledge
- Sharing medications
- Unapproved opioid use to treat another symptom (e.g., insomnia)

Aberrant behaviors suggestive of addiction &/or diversion

- Use of illicit drugs or unprescribed opioids
- Repeatedly obtaining opioids from multiple outside sources
- Prescription forgery
- Multiple episodes of prescription loss

Optional Slide

Taper Dose When Discontinuing

Taper dose to avoid withdrawal symptoms in opioid dependent patient

Recommend outpatient setting for patients without severe medical or psychiatric comorbidities

Recommend rehabilitation setting for patients unable to reduce opioid dose in less structured settings

- When aberrant drug-related behaviors continue, may need to enforce tapering efforts

May use a range of approaches from slow 10% dose reduction per week to more rapid 25%-50% reduction every few days

Case:

Ernestine
42 yo. female

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Case:

Ernestine

42 yo. female with severe Rheumatoid Arthritis followed through local pain clinic for 2 years with escalating Opiate requirements.

Presently on Oxycodone ER 20mg Q12 and Hydrocodone 5mg Q6 prn breakthrough pain.

Presents Saturday at 2pm because :

- **Scenario I** – Local clinic closed by DEA secondary to violation of State Pill Mill Regulations.
- **Scenario II** – Fired from pain clinic on Friday because of UDT (+) FOR Methadone & Methamphetamine in violation of pain contract.

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Ernestine
Scenario I – Clinic Closed

A	Confirm through DEA if possible.
B	Assess PMP to evaluate compliance, variance, and possible number of expected residual pills until run out
C	If story is legitimate, consider prescribing short bridging prescription with follow-up confirmed at primary provider who can help moving forward
D	Carefully document research done, plan agreed upon, and fact that patient understands no refills through ED

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Ernestine
Scenario II – Violation of contract

A Provider is not the villain. Stick to rules, and understand violation of contract has consequences. Contact prior provider as needed..

B Explore alternatives to ease symptoms of withdrawal:

I. NSAID
II. Anti-emetics
III. Anti-spasmodic

I. Clonidine patch for Blood pressure swings
II. Muscle relaxant (non-restricted)
III. Anti-histamines
IV. Other

C Look for inpatient detoxification programs at patients request

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Pearls for Practice

Treat Initiation of Opioids as a Therapeutic Trial

Anticipate ER/LA Opioid-Induced Respiratory Depression

It can be immediately life-threatening

Be Conservative and Thoughtful In Dosing

When initiating, titrating, and rotating opioids
First calculate equinalgesic dose, then reduce dose appropriately

Discontinue ER/LA opioids slowly and safely

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MANAGING ER/LA OPIOID DEPENDANT PATIENTS IN THE ED SETTING

Unit III

Opioid Therapy

Before initiating a trial of opioid analgesic therapy, confirm patient understanding of informed consent to establish:

- **Analgesic & functional goals of treatment**
- **Expectations**
- **Potential risks**
- **Alternatives to opioids**

The potential for & how to manage:

- Common opioid-related AEs (e.g., constipation, nausea, sedation)
- Other serious risks (e.g., abuse, addiction, respiratory depression, overdose)
- AEs after long-term or high-dose opioid therapy (e.g., hyperalgesia, endocrinologic or sexual dysfunction)

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Patient-Prescriber Agreement (PPA)

Document signed by both patient & prescriber at time an opioid is prescribed

- **Clarify treatment plan & goals of treatment w/ patient, patient's family, & other clinicians involved in patient's care**
- **Assist in patient education**
- **Inform patients about the risks & benefits**
- **Document patient & prescriber responsibilities**

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Consider a PPA

Reinforce expectations for appropriate & safe opioid use

- Obtain opioids from a single prescriber
- Fill opioid prescriptions at a designated pharmacy
- Safeguard opioids
  - Do not store in medicine cabinet
  - Keep locked (e.g., use a medication safe)
  - Do not share or sell medication
- Instructions for disposal when no longer needed
- Commitments to return for follow-up visits
- Comply w/ appropriate monitoring
  - E.g., random UDT & pill counts
- Frequency of prescriptions
- Enumerate behaviors that may lead to opioid discontinuation
- An exit strategy
- Appropriate indications to go to the emergency department

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Monitor Patients During Opioid Therapy

Therapeutic risks & benefits do not remain static	Identify patients	Periodically assess continued need for opioid analgesic
Affected by change in underlying pain condition, coexisting disease, or psychologic/ social circumstances	• Who are benefiting from opioid therapy • Who might benefit more w/ restructuring of treatment or receiving additional services (e.g., addiction treatment) • Whose benefits from treatment are outweighed by risks	Re-evaluate underlying medical condition if clinical presentation changes

Monitor Patients During Opioid Therapy, cont'd

Periodically evaluate:	Patients requiring more frequent monitoring include:
• Pain control – Document pain intensity, pattern, & effects • Functional outcomes – Document level of functioning – Assess progress toward achieving therapeutic goals • Health-related QOL • AE frequency & intensity • Adherence to prescribed therapies	• High-risk patients • Patients taking high opioid doses

Anticipate & Treat Common AEs

Constipation	**most common AE; does not resolve with time**
• Initiate a bowel regimen before constipation develops • Increase fluid & fiber intake, stool softeners, & laxatives • Opioid antagonists may help prevent/treat opioid-induced bowel dysfunction	
Nausea & vomiting	**tend to diminish over days or weeks**
Oral & rectal antiemetic therapies as needed	
Drowsiness & sedation	**tend to wane over time**
Counsel patients about driving, work & home safety as well as risks of concomitant exposure to other drugs & substances w/ sedating effects	
Pruritus & myoclonus	**tend to diminish over days or weeks**
Treatment strategies for either condition largely anecdotal	

Chou R, et al. J Pain. 2009;10(2):113-30.

Monitor Adherence and Aberrant Behavior

Routinely monitor patient adherence to treatment plan

- Recognize & document aberrant drug-related behavior
  - In addition to patient self-report also use:
    - State PDMPs, where available
    - UDT
      - Positive for nonprescribed drugs
      - Positive for illicit substance
      - Negative for prescribed opioid
- Family member or caregiver interviews
- Monitoring tools such as the COMM, PADT, PMQ, or PDUQ
- Medication reconciliation (e.g., pill counts)

PADT=Pain Assessment & Documentation Tool

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Address Aberrant Drug-Related Behavior

Behavior outside the boundaries of agreed-on treatment plan:

Behaviors that are **less** indicative of aberrancy	Behaviors that are **more** indicative of aberrancy
Unsanctioned dose escalations or other noncompliance w/ therapy on 1 or 2 occasions	**Multiple dose escalations or other noncompliance w/ therapy despite warnings**
Unapproved use of the drug to treat another symptom	**Prescription forgery**
Openly acquiring similar drugs from other medical sources	**Obtaining prescription drugs from nonmedical sources**

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Prescription Drug Monitoring Programs (PDMPs)

48 states have an operational PDMP
1 state & DC have enacted PDMP legislation, not yet operational
1 state has no legislation

Individual state laws determine

- Who has access to PDMP information
- Which drug schedules are monitored
- Which agency administers the PDMP
- Whether prescribers are required to register w/ the PDMP
- Whether prescribers are required to access PDMP information in certain circumstances
- Whether unsolicited PDMP reports are sent to prescribers

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PDMP Benefits

Record of a patient's controlled substance prescriptions	Provide warnings of potential misuse/abuse
• Some are available online 24/7 • Opportunity to discuss w/ patient	• Existing prescriptions not reported by patient • Multiple prescribers/pharmacies • Drugs that increase overdose risk when taken together • Patient pays for drugs of abuse w/ cash

Prescribers can check their own prescribing Hx

Creative Solutions to PMP Access

Record of a patient's controlled substance prescriptions	Provide warnings of potential misuse/abuse
• Some are available online 24/7 • Opportunity to discuss w/ patient	• Existing prescriptions not reported by patient • Multiple prescribers/pharmacies • Drugs that increase overdose risk when taken together • Patient pays for drugs of abuse w/ cash

Prescribers can check their own prescribing Hx

Creative Solutions to PMP Access, cont'd

Washington State Emergency Department Information Exchange

Real-time push system to every Emergency Department in the state at the time of registration and medical screening exam

Contains:

- List of ED visits in the last twelve months
- Care Management Plans
- PMP Results with specific filter to avoid "PMP Fatigue" to highlight risks

Single Provider

Date	Rx #	Drug Name and strength	Quantity	Days Supply	Dispensing Pharmacy	Prescriber	Patient Name	Date of Birth	Pay Source
1/14/2014	1234567	Oxycontin 30mg	60	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
1/14/2014	1234568	Alprazolam 1mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
1/14/2014	1234569	Zolpiodem 10mg	30	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
2/12/2014	2345671	Oxycontin 30mg	60	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
2/12/2014	1234568	Alprazolam 1mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
2/12/2014	1234569	Zolpiodem 10mg	30	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
3/13/2014	3456712	Oxycontin 30mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
3/13/2014	1234568	Alprazolam 1mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
3/13/2014	1234569	Zolpiodem 10mg	30	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
4/11/2014	4567123	Oxycontin 30mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
4/11/2014	4567124	Oxycodone 5mg	120	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
4/11/2014	1234568	Alprazolam 1mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
4/11/2014	1234569	Zolpiodem 10mg	30	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
5/8/2014	5671234	Oxycontin30mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
5/8/2014	5671235	Oxycodone 5mg	120	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
5/8/2014	1234568	Alprazolam 1mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
5/8/2014	1234569	Zolpiodem 10mg	30	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
6/6/2014	6712345	Oxycontin 40mg	60	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
6/6/2014	6712346	Oxycodone 10mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
6/6/2014	1234568	Alprazolam 1mg	90	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp
6/6/2014	1234569	Zolpiodem 10mg	30	30	Pharmacy A	Presriber A	Test Patient	12/1/1800	Work Comp

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Multiple Providers

Date	Rx #	Drug Name and strength	Quantity	Days Supply	Dispensing Pharmacy	Prescriber	Patient Name	DOB	Pay Source
1/5/2014	1234567	Morphine ER 30mg	60	30	Pharmacy A	Prescriber A	Test Patient	10/1/1700	Medicaid
1/5/2014	1234568	Lorazepam 1mg	60	30	Pharmacy A	Prescriber A	Test Patient	10/1/1700	Medicaid
2/1/2014	9876543	Morphine ER 30mg	90	30	Pharmacy B	Prescriber B	Test Patient	10/1/1700	Medicaid
2/1/2014	9876544	Alprazolam 2mg	60	30	Pharmacy B	Prescriber B	Test Patient	10/1/1700	Medicaid
2/28/2014	6543217	Kaidan 20mg	60	30	Pharmacy C	Prescriber C	Test Patient	10/1/1700	Medicaid
2/28/2014	6543218	Alprazolam 2mg	90	30	Pharmacy C	Prescriber C	Test Patient	10/1/1700	Medicaid
2/28/2014	6543219	Temazepam 30mg	30	30	Pharmacy C	Prescriber C	Test Patient	10/1/1700	Medicaid
3/25/2014	9518473	Oxymorphone 30mg	90	30	Pharmacy A	Prescriber D	Test Patient	10/1/1700	Medicaid
3/25/2014	1234568	Lorazepam 1mg	60	30	Pharmacy A	Prescriber A	Test Patient	10/1/1700	Medicaid
3/27/2014	6543219	Temazepam 30mg	30	30	Pharmacy C	Prescriber C	Test Patient	10/1/1700	Medicaid
4/19/2014	13456798	Hydromorphone 8mg ER	90	30	Pharmacy B	Prescriber E	Test Patient	10/1/1700	Medicaid
4/19/2014	13456799	Alprazolam 2mg	90	30	Pharmacy B	Prescriber E	Test Patient	10/1/1700	Medicaid
4/19/2014	13456800	Zolpidem10mg	30	30	Pharmacy B	Prescriber E	Test Patient	10/1/1700	Medicaid
5/15/2014	14567983	Hydromorphone 8mg ER	90	30	Pharmacy B	Prescriber E	Test Patient	10/1/1700	Medicaid
5/15/2014	13456799	Alprazolam 2mg	90	30	Pharmacy B	Prescriber E	Test Patient	10/1/1700	Medicaid
5/15/2014	13456800	Zolpidem10mg	30	30	Pharmacy B	Prescriber E	Test Patient	10/1/1700	Medicaid
5/17/2014	6543219	Temazepam 30mg	30	30	Pharmacy C	Prescriber C	Test Patient	10/1/1700	Cash
6/14/2014	15679834	Oxycontin 20mg	60	30	Pharmacy B	Prescriber B	Test Patient	10/1/1700	Medicaid
6/14/2014	15679835	Oxycodone 10mg	120	30	Pharmacy B	Prescriber B	Test Patient	10/1/1700	Medicaid
6/14/2014	15679836	Lorazepam 2mg	60	30	Pharmacy B	Prescriber B	Test Patient	10/1/1700	Medicaid
6/14/2014	6543219	Temazepam 30mg	30	30	Pharmacy C	Prescriber C	Test Patient	10/1/1700	Cash

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PDMP Unsolicited Patient Threshold Reports

Reports automatically generated on patients who cross certain thresholds when filling prescriptions. Available in some states.

E-mailed to prescribers to whom prescriptions were attributed

Prescribers review records to confirm it is your patient & you wrote the prescription(s) attributed to you

If inaccurate, contact PDMP

If you wrote the prescription(s), patient safety may dictate need to discuss the patient w/ other prescribers listed on report

- Decide who will continue to prescribe for the patient & who might address drug abuse concerns.

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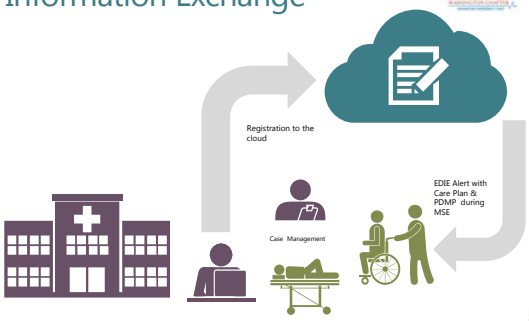
Emergency Department Information Exchange



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Rationale for Urine Drug Testing (UDT)

Help to identify drug misuse/addiction

- Prior to starting opioid treatment

Assist in assessing adherence during opioid therapy

- As requirement of therapy w/ an opioid
- Support decision to refer

UDT frequency is based on clinical judgment

Depending on patient's display of aberrant behavior and whether it is sufficient to document adherence to treatment plan

Check state regulations for requirements

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Main Types of UDT Methods

Initial testing w/ IA drug panels:

- Classify substance as present or absent according to cutoff
- Many do not identify individual drugs within a class
- Subject to cross-reactivity
- Either lab based or at POC

Identify specific drugs &/or metabolites w/ sophisticated lab-based testing; e.g., GC/MS or LC/MS*

- Specifically confirm the presence of a given drug
  - e.g., morphine is the opiate causing a positive IA*
- Identify drugs not included in IA tests
- When results are contested

* GC/MS=gas chromatography/ mass spectrometry
IA=immunoassay
LC/MS=liquid chromatography/ mass spectrometry

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Detecting Opioids by UDT

Most common opiate IA drug panels

- Detect "opiates" morphine & codeine, but doesn't distinguish
- Do not reliably detect semisynthetic opioids
  - Specific IA panels can be ordered for some
- Do not detect synthetic opioids (e.g., methadone, fentanyl)
  - Only a specifically directed IA panel will detect synthetics

GC/MS or LC/MS will identify specific opioids

- Confirm presence of a drug causing a positive IA
- Identify opioids not included in IA drug panels, including semisynthetic & synthetic opioids
- Identify opioids not included in IA drug panels, including semisynthetic & synthetic opioids

Specific Windows of Drug Detection

Optional Slide

How long a person excretes drug &/or metabolite(s) at a concentration above a cutoff

Detection time of drugs in urine

Governed by various factors; e.g., dose, route of administration, metabolism, fat solubility, urine volume, & pH

For most drugs it is 1-3 days

Chronic use of lipid-soluble drugs increases detection time; e.g., marijuana, diazepam, ketamine

Specific Windows of Drug Detection, cont'd

Optional Slide

Drug in urine	Time
Amphetamines	≤3 d
THC (depending on grade & frequency of use) – Single use – Chronic use	 1-3 d ≤ 30 d
Benzoylecgonine after cocaine use	2-4 d
Opiates (morphine, codeine)	2-3 d
Methadone – EDDP (methadone metabolite)	≤3 d ≤6 d
Benzodiazepines (depending on drug & dose)	Days to wks

EDDP=2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine

Interpretation of UDT Results

Positive Result

Demonstrates recent use
- Most drugs in urine have detection times of 1-3 d
- Chronic use of lipid-soluble drugs: test positive for ≥1 wk

Does not diagnose
- Drug addiction, physical dependence, or impairment

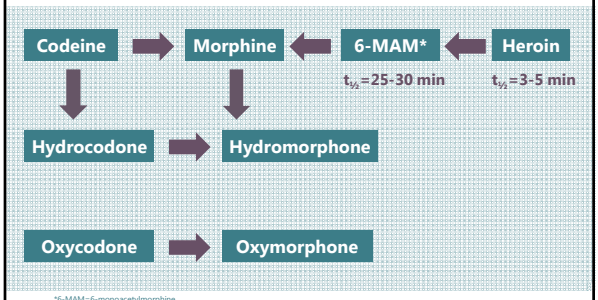
Does not provide enough information to determine
- Exposure time, dose, or frequency of use

Negative Result

Does not diagnose diversion
- More complex than presence or absence of a drug in urine

May be due to maladaptive drug-taking behavior
- Bingeing, running out early
- Other factors: eg, cessation of insurance, financial difficulties

Examples of Metabolism of Opioids



*6-MAM=6-monoacetylmorphine

Interpretation of UDT Results

Use UDT results in conjunction w/ other clinical information

Investigate unexpected results

Discuss w/ the lab

Chart results, interpretation, & action

Do not ignore the *unexpected* positive result

May necessitate closer monitoring &/or referral to a specialist
*** ie: addiction or pain management**

Open discussion with patient & consider including prescribing primary / provider in loop

Gourlay DL, et al. *Urine Drug Testing in Clinical Practice. The Art & Science of Patient Care.* Ed 4. 2010.

ER/LA Opioid Use in Pregnant Women

No adequate & well-controlled studies

Only use if potential benefit justifies the risk to the fetus

Be aware of the pregnancy status of your patients

If prolonged use is required during pregnancy:
- Advise patient of risk of neonatal withdrawal syndrome
- Ensure appropriate treatment will be available

Be Ready to Refer

Be familiar w/ referral sources for abuse or addiction that may arise from use of ER/LA opioids

SAMHSA substance abuse treatment facility locator

http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx

SAMHSA mental health treatment facility locator

http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/quickSearch.jspx

Challenge: The Insistent Patient

Optional Slide

Red Flag:

Patient refuses to consider non-opioid treatment options

Mr. Lee's presenting pain complaint in ED appears in excess to exam. Records/PMP suggest frequent uncoordinated opiate use. You suggest trying alternative pain management options. He is extremely resistant and tells you "Nothing else relieves my pain."

Action: Work with your patient to set treatment goals and expectations. Select and document a therapy plan that is in compliance with an existing patient-provider agreement. Evaluate Mr. Lee for potential addiction; consider referral to psychiatry or addiction medicine.

Case:

Tony
40 yo. male

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Case:

Tony

Tony is a 42-year-old with a history of chronic back pain that he is on disability for.

He presents to your emergency department at 2am Saturday morning on Memorial weekend stating that his back pain is worse and he is out of his Opana.

He states that he has an appointment with his primary next week Thursday.

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Tony

PMH	Chronic Back Pain, Bipolar Disorder
Social History:	Smoker, occasional alcohol
FamHx:	HTN, Alcoholism
Medications:	Medications: Opana
Exam:	Pt has stable vitals, is able to ambulate without difficulty and normal neurologic function. Back exam yields no spinous process tenderness only soreness over lower back muscles.

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Tony

PDMP

- Monthly Opana from PCP
- Recent opiate scripts from different providers just prior to his scheduled refill

UDS

Positive for

- Benzos
- Opiates
- Oxycodone

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Opioid Risk Tool

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	———	———
		Total Score Risk Category		

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ORT

3	Fam Hx of alcohol abuse
5	History of prescription abuse
1	Male age 16-45
2	Bipolar History
TOTAL 11	Pt is high risk for aberrant behavior.

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Case:

How to Proceed?

1. It's a busy holiday weekend and writing him a script for 10 pills should get him out of your hair quickly.
2. Say no to Opana and offer NSAIDs and muscle relaxant and discharge.
3. Contact primary prescriber to discuss case. Discuss the treatment option with pt which will include NSAID, Muscle relaxant, Gabapentin.

Case:

How to Proceed?

1. It's a busy holiday weekend and writing him a script for 10 pills should get him out of your hair quickly.
2. Say no to Opana and offer NSAIDs and muscle relaxant and discharge.
3. CORRECT — Contact primary prescriber to discuss case. Discuss the treatment option with pt which will include NSAID, Muscle relaxant, Gabapentin.

Case:

Escalating Patient

Tony states **"I'll either be back tomorrow, in withdrawal, or I'll just have to go back to heroin, and neither of us want me to do that!"**

You discuss with pt his PDMP results and talk about his contract with his PCP. Pt's escalating behavior makes him the highest risk patient.

Case:

How to Manage

1	Be clear on the rules and threats don't change the rules. Reemphasize his contract with his PCP and that you will not violate the contract.
2	Emphasize that you care and that you are listening.
3	Offer medications to help with withdrawal symptoms such as: clonidine patch, muscle relaxant, anti-nausea & anti-diarrheal meds, dicyclomine, anti-histamines.
4	Offer referral to substance abuse program or see if patient qualifies for inpatient help as pt desires

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Pearls for Practice

- Anticipate and Treat Common Adverse Effects
- Use Informed Consent and refer to Patient Provider Agreements
- Use UDT and PDMP as Valuable Sources of Data About your Patient
  - ***However, know their limitations***
- Assess for Patient Adherence, Side Effects, Aberrant Behaviors, and Clinical Outcomes
- Refer Appropriately if Necessary
- Coordinate ED management with Primary Prescribing Provider

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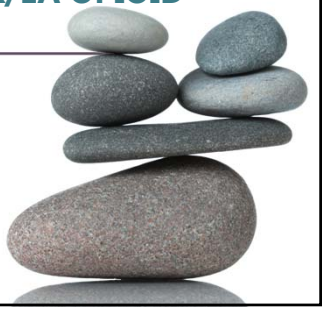
COUNSELING PATIENTS & CAREGIVERS ABOUT THE SAFE USE OF ER/LA OPIOID ANALGESICS

Unit IV



Use **Patient Counseling Document** to help counsel patients

Download:
www.er-la-opioidrems.com/IwgUI/rems/pdf/patient_counseling_document.pdf

Order hard copies:
www.minneapolis.cenveo.com/pcd/SubmitOrders.aspx


Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics

Patient Name:

The DOs and DON'Ts of Extended-Release / Long - Acting Opioid Analgesics

DO:
- Read the Medication Guide
- Take your medicine exactly as prescribed
- Store your medicine away from children and in a safe place
- Flush unused medicine down the toilet
- Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Call 911 or your local emergency service right away if:
- You take too much medicine
- You have trouble breathing, or shortness of breath
- A child has taken this medicine

Talk to your healthcare provider:
- If the dose you are taking does not control your pain
- About any side effects you may be having
- About all the medicines you take, including over-the-counter medicines, vitamins, and dietary supplements

DON'Ts
- Do not give your medicine to others.
- Do not take medicine unless it was prescribed for you.
- Do not stop taking your medicine without talking to your healthcare provider
- Do not cut, break, chew, crush, dissolve, snort, or inject your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider
- Do not drink alcohol while taking this medicine

For additional information on your medicine go to dailymed.nlm.nih.gov

Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics

Patient Name:

Patient Specific Information

Take this card with you every time you see your healthcare provider and tell him/her:
- Your complete medical and family history, including any history of substance abuse or mental illness
- If you are pregnant or are planning to become pregnant
- The cause, severity, and nature of your pain
- Your treatment goals
- All the medicines you take, including over-the-counter non-prescription medicines, vitamins, and dietary supplements
- Any side effects you may be having

Take your opioid pain medicine exactly as prescribed by your healthcare provider.

FDA. *EXTENDED-RELEASE (ER) AND LONG-ACTING (LA) OPIOID ANALGESICS RISK EVALUATION AND MITIGATION STRATEGY (REMS)* Modified 08/2014. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM311290.pdf

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Counsel Patients About Proper Use

Explain	Instruct patients/ caregivers to
• Product-specific information about the prescribed ER/LA opioid • How to take the ER/LA opioid as prescribed • Importance of adherence to dosing regimen, handling missed doses, & contacting their prescriber if pain cannot be controlled	• Read the ER/LA opioid **Medication Guide** received from pharmacy **every time** an ER/LA opioid is dispensed • At every medical appointment explain all medications they take

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Counsel Patients About Proper Use, cont'd

Counsel patients/caregivers:
- On the most common AEs of ER/LA opioids
- About the risk of falls, working w/ heavy machinery, & driving
- Call the prescriber for advice about managing AEs
- Inform the prescriber about AEs

Prescribers should report serious AEs to the FDA:
www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf
or **1-800-FDA-1088**

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Warn Patients

Never break, chew, crush or snort an oral ER/LA tablet/capsule, or cut or tear patches prior to use

- May lead to rapid release of ER/LA opioid causing overdose & death
- When a patient cannot swallow a capsule whole, prescribers should refer to PI to determine if appropriate to sprinkle contents on applesauce or administer via feeding tube

Use of CNS depressants or alcohol w/ ER/LA opioids can cause overdose & death

- Use with alcohol may result in rapid release & absorption of a potentially fatal opioid dose
- Other depressants include sedative-hypnotics & anxiolytics, illegal drugs

Warn Patients, cont'd

Misuse of ER/LA opioids can lead to death

- Take **exactly** as directed*
- Counsel patients/caregivers on risk factors, signs, & symptoms of overdose & opioid-induced respiratory depression, GI obstruction, & allergic reactions
- Call **911** or poison control **1-800-222-1222**

***Serious side effects, including death, can occur even when used as recommended**

Do not abruptly stop or reduce the ER/LA opioid use

- Discuss how to safely taper the dose when discontinuing

Optional Slide

POISON Help
1-800-222-1222

WARNING:

A person who at first only seems to be overmedicated may get much worse. **They should be kept awake & watched closely.**

If a child or pet ever swallows an opioid that was not prescribed for them, it is ***always an emergency***. Call for help immediately.

Signs to Watch For - Overmedication or Overdose?
(Share this with your caregivers.)

Overmedication Warning - Call Healthcare Provider
U.S. residents also can call the National Poison Hotline at 1-800-222-1222.

- Intoxicated behavior - confusion, slurred speech, stumbling.
- Feeling dizzy or faint.
- Feeling or acting very drowsy or groggy, or nodding off to sleep.
- Unusual snoring, gasping, or snorting during sleep.
- Difficulty waking-up from sleep and becoming alert or staying awake.

Overdose Poisoning - Call Emergency Services
Dial 911 in the US or Canada

- Person cannot be aroused or wakened, or is unable to talk if awakened.
- Any trouble with breathing; such as shortness of breath, slow or light breathing, or stopped breathing.
- Gurgling noises coming from mouth or throat.
- Body is limp, seems lifeless. Face is pale, clammy.
- Fingernails or lips turned blue/purple.
- Slow or unusual heartbeat or stopped heartbeat.

Opioids911-Safety: Help for Safely Using Opioid Pain Relievers. Pain Treatment Topics. http://opioids911.org/emergencies.php

Consider Prescribing Naloxone

Naloxone:

- An opioid antagonist
- Antidote to acute opioid toxicity
- Instruct patients to use in event of known or suspected overdose, **in addition to calling emergency services**

Available as:

- Naloxone kit (w/ syringes & needles)
- EVZIO™ (naloxone HCl) auto-injector

Candidates for naloxone include those:

- Taking high-doses of opioids
- Taking opioid preparations that may increase risk for overdose; eg, ER/LA opioids
- Undergoing opioid rotation
- Discharged from emergency medical care following opioid intoxication/poisoning
- Legitimate medical need for analgesia, coupled with suspected/confirmed substance abuse

Encourage patients to:

- Create an "overdose plan"
- Involve friends, family members, partners, &/or caregivers

SAMHSA. *SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 14-4742.* Rockville, MD. 2014.

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Naloxone Training Programs

- Dope (Drug Overdose Prevention and Education) Project, SF 2001
- Staying Alive, Baltimore, MD 2004
- Project Lazarus, NC 2008
- Chicago Recovery Alliance 2001
- Opioid overdose and prevention, NM 2001
- Massachusetts Overdose Education Naloxone Distribution Center, Boston, MA 2000-4 (underground)

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Must be coupled with education

- Identify opioids
- Recognize an OD (opioid vs. not)
- Rouse victim
- Call 911
- Rescue breathing
- Give naloxone
- Left lateral decubitus
- Aftercare

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Protecting the Community

Caution Patients

- **Sharing ER/LA opioids w/ others may cause them to have serious AEs**
  - Including death
- **Selling or giving away ER/LA opioids is against the law**
- **Store medication safely and securely**
- **Protect ER/LA opioids from theft**
- **Dispose of any ER/LA opioids when no longer needed**
  - Read product-specific disposal information included w/ ER/LA opioid

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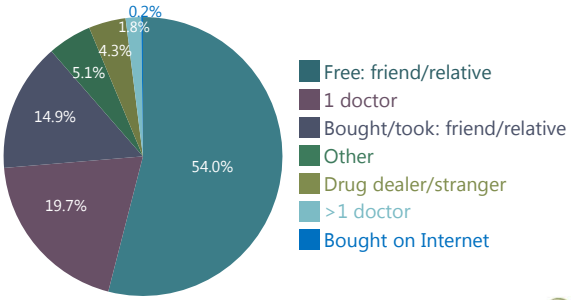
Source of Most Recent Rx Opioids Among Past-Year Users (2011-2012)



SAMHSA. (2013). *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings.* NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD.

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Educate Patients & Families

Rx medicines should only be taken when prescribed to you by a provider
- Taking a pill prescribed for someone else is drug abuse and illegal, "even just once"

Misusing Rx drugs can be as dangerous as illegal "street" drugs

Mixing Rx opioids w/ alcohol or w/ sedatives / hypnotics is potentially fatal

Parents Should Set Good Examples & Educate Teens

Optional Slide

Parent Survey

- 45% of parents have taken pain medications w/o a prescription at some point
- 14% have given their children pain medications w/o a prescription

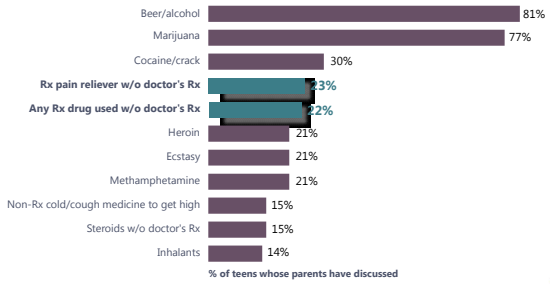
Teen Survey

Teens continue to report that their parents do not talk to them about the risks of prescription drugs at the same levels of other abused substances

Substances Parents Have Discussed With Teens*

Optional Slide

*As reported by teens



Educate Parents: Not in My House

Step 1: Monitor

- Note how many pills in each prescription bottle or pill packet
- Keep track of refills for all household members
- If your teen has been prescribed a drug, coordinate & monitor dosages & refills
- Make sure friends & relatives—especially grandparents—are aware of the risks
- If your teen visits other households, talk to the families about safeguarding their medications

Educate Parents: Not in My House, cont'd

Step Two: Secure

- Do not store prescription meds in the medicine cabinet
- Keep meds in a safe place (e.g., locked cabinet)
- Tell relatives, especially grandparents, to lock meds or keep in a safe place
- Encourage parents of your teen's friends to secure meds

Step Three: Dispose

- Take inventory of all prescription drugs in your home
- Discard expired or unused meds

Rx Opioid Disposal

New "Disposal Act" expands ways for patients to dispose of unwanted/expired opioids

Decreases amount of opioids introduced into the environment, particularly into water

Collection receptacles
Call DEA Registration Call Center at **1-800-882-9539** to find a local collection receptacle

Mail-back packages
Obtained from authorized collectors

Local take-back events
- Conducted by Federal, State, tribal, or local law enforcement
- Partnering w/ community groups

Voluntarily maintained by:
- Law enforcement
- Authorized collectors, including:
  - Manufacturer
  - Distributer
  - Reverse distributer
  - Retail or hospital/clinic pharmacy
    - Including long-term care facilities

Last DEA National Prescription Drug Take-Back Day on September 27, 2014

DEA. *Federal Register*. 2014; 79(174):53520-70. Final Rule. Disposal of Controlled Substances. [Docket No. DEA-316] www.deadiversion.usdoj.gov/fed_regs/rules/2014/2014-20926.pdf
DEA. Disposal Act: General Public Fact Sheet. www.deadiversion.usdoj.gov/drug_disposal/fact_sheets/disposal_public.pdf

Other Methods of Opioid Disposal

If collection receptacle, mail-back program, or take-back event unavailable, throw out in household trash

- Take drugs out of original containers
- Mix w/ undesirable substance, e.g., used coffee grounds or kitty litter
  - Less appealing to children/pets, & unrecognizable to people who intentionally go through your trash
- Place in sealable bag, can, or other container
  - Prevent leaking or breaking out of garbage bag
- Before throwing out a medicine container
  - Scratch out identifying info on label

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Prescription Drug Disposal

FDA lists especially harmful medicines – in some cases fatal w/ just 1 dose – if taken by someone other than the patient
- Instruct patients to check medication guide

Flush down sink/toilet if no collection receptacle, mail-back program, or take-back event available

- **As soon as they are no longer needed**
  - So cannot be accidentally taken by children, pets, or others
- **Includes transdermal adhesive skin patches**
  - Used patch worn for 3d still contains enough opioid to harm/kill a child
  - Dispose of used patches immediately after removing from skin
- **Fold patch in half so sticky sides meet, then flush down toilet**
- **Do NOT place used or unneeded patches in household trash**
  - Exception is Butrans: can seal in Patch-Disposal Unit provided & dispose of in the trash

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Optional Slide

Case:

Anne
47-Year-Old Female

Anne presents to ED at 5pm on Friday before a Holiday weekend because she is out of her medication, and can't see her regular doctor until "at least Tuesday or Wednesday".

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Case:

Optional Slide

Anne

Anne has ovarian cancer

Stable disease based on recent imaging	Stable pain management for 1 yr w/hydromorphone ER 12 mg q24h	Last 2 months she asked for a renewal prescription 5-7 days early • When questioned did not realize she was requesting refills early
Query your state PDMP: she has not been doctor shopping	Collect urine sample: send to lab for pain management panel that includes hydromorphone, opiates, & drugs of abuse	She reports no change in her pain control • Current regimen is still effective

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Optional Slide

Anne: What Would You Do Next?

1. Refuse to give her a refill until the "correct" time
2. Make her next prescription for only 2 weeks & have her bring in her pill bottles for a count at next visit
3. Ask where she keeps her medications & how she secures them

Answer 3 is correct

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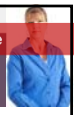
Optional Slide

Anne: Interview



Anne reports that she keeps her medications in her purse on top of the refrigerator

Further questioning reveals that her niece & nephews have recently visited her home more often than usual

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Anne: What Now? Should You:

Optional Slide

1. Only prescribe 2 wks of hydromorphone ER at a time & request she brings in her prescription bottles for pill counts at each visit
2. Stress to her the safety concerns when ER/LA opioids are taken by someone for whom they are not prescribed; request she brings her prescription bottles for pill count next visit
3. Call the police

Answer 2 is correct

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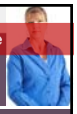
Anne: Case Summary

Optional Slide



Explain to Anne

- ER/LA opioids are extremely harmful—can be fatal w/ just 1 dose—if taken by someone other than the patient
- She is responsible for storing medication in a safe & secure place away from children, family members, & visitors
- If she cannot safeguard her medications, you will consider an alternative therapy

You will not provide early renewal of prescription again

At the next visit

- UDT positive for hydromorphone (negative other drugs)
- Anne reports she
  - Purchased a medication safe that same day
  - Counts her medication daily
  - Spoke to her sister regarding concerns about her niece/nephews

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Challenge: The Offended Patient

Optional Slide

Red Flag:

You decide not to request routine risk assessment for fear of creating conflict

Mrs. Jorgensen has been coming to your ED for 8 years but recently in the last 3-5 months has markedly increased visits for a constellation of non-visible traumatic complaints. Searching PMP shows a consistent monthly prescription from her PCP for an ER/LA product. When you ask her to under go urine drug testing, she becomes upset and accuses you of not trusting her.

Action: Describe UDT as a routine part of medication monitoring rather than a "drug test". Create a department policy for performing UDT on all ER/LA opioid patients. Practice by following universal precautions. Refer to ER/LA products and involve a patient-provider agreement to clarify expectations of treatment and contact with your PCP .

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Optional Slide

Challenge: The Daughter's Party

Red Flag:

Patients do not safeguard their opioid medications correctly

Your patient's daughter, Jody, stole her father's opioids from his bedside drawer to take to a "fishbowl party". Her best friend consumed a mix of opioids and alcohol and died of an overdose.

Action: Always counsel patients about safe drug storage; warn patients about the serious consequences of theft, misuse, and overdose. Tell your patients that taking another person's medication, even once, is against the law.

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Pearls for Practice

Establish Informed Consent

Counsel Patients about Proper Use

- ***Appropriate use of medication***
- ***Consequences of inappropriate use***

Educate the Whole Team

- ***Patients, families, caregivers***

Tools and Documents Can Help with Counseling

- ***Use them!***

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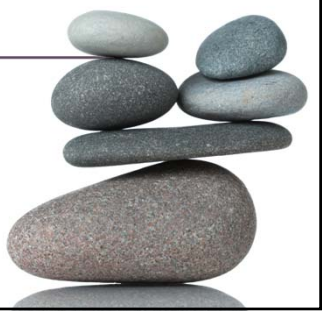
GENERAL DRUG INFORMATION FOR ER/LA OPIOID ANALGESIC PRODUCTS

Unit V



General ER/LA Opioid Drug Information

Prescribers should be knowledgeable about general characteristics, toxicities, & drug interactions for ER/LA opioid products:

ER/LA opioid analgesic products are scheduled under the Controlled Substances Act & can be misused & abused

Respiratory depression is the most serious opioid AE

Can be immediately life-threatening

Constipation is the most common long-term AE

Should be anticipated

For Safer Use: Know Drug Interactions, PK, & PD

CNS depressants can potentiate sedation & respiratory depression

Some ER/LA products rapidly release opioid (dose dump) when exposed to alcohol
Some drug levels may increase without dose dumping

Use w/ MAOIs may increase respiratory depression
Certain opioids w/ MAOIs can cause serotonin syndrome

Can reduce efficacy of diuretics
Inducing release of antidiuretic hormone

Methadone & buprenorphine can prolong QTc interval

Drugs that inhibit or induce CYP enzymes can increase or lower blood levels of some opioids

Opioid Tolerant

Tolerance to sedating & respiratory-depressant effects is critical to safe use of certain ER/LA opioid products, dosage unit strengths, or doses

Patients must be opioid tolerant before using

- Any strength of transdermal fentanyl or hydromorphone ER
- Certain strengths or daily doses of other ER products

Opioid-tolerant patients are those taking at least

- 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hr
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- An equianalgesic dose of another opioid

FOR 1 WK OR LONGER

Key Instructions: ER/LA Opioids

- **Individually titrate to a dose that provides adequate analgesia & minimizes adverse reactions**
- **Times required to reach steady-state plasma concentrations are product-specific**
- **Refer to product information for titration interval**
- **Continually re-evaluate to assess maintenance of pain control & emergence of AEs**

Key Instructions: ER/LA Opioids, cont'd

- During chronic therapy, especially for non-cancer-related pain, periodically reassess the continued need for opioids
- If pain increases, attempt to identify source, while adjusting dose
- When an ER/LA opioid is no longer required, gradually titrate dose downward to prevent signs & symptoms of withdrawal in physically dependent patients

Do not abruptly discontinue!

Common Drug Information for This Class

Limitations of usage	Dosage reduction for hepatic or renal impairment	Relative potency to oral morphine
• Reserve for when alternative options (eg, non-opioids or IR opioids) are ineffective, not tolerated, or otherwise inadequate • Not for use as an as-needed analgesic • Not for mild pain or pain not expected to persist for an extended duration • Not for acute pain	See individual drug PI	• Intended as general guide • Follow conversion instructions in individual PI • Incomplete cross-tolerance & inter-patient variability require conservative dosing when converting from 1 opioid to another – Halve calculated comparable dose & titrate new opioid as needed

Transdermal Dosage Forms

Do not cut, damage, chew, or swallow

- Exertion or exposure to external heat can lead to fatal overdose
- Rotate location of application
- Prepare skin: clip - not shave - hair & wash area w/ water
- Monitor patients w/ fever for signs or symptoms of increased opioid exposure
- Metal foil backings are not safe for use in MRIs

Drug Interactions Common to this Class

- **Concurrent use w/ other CNS depressants can increase risk of respiratory depression, hypotension, profound sedation, or coma**
  Reduce initial dose of one or both agents
- **Avoid concurrent use of partial agonists* or mixed agonist/antagonists† with full opioid agonist**
  May reduce analgesic effect &/or precipitate withdrawal
- **May enhance neuromuscular blocking action of skeletal muscle relaxants & increase respiratory depression**
- **Concurrent use w/ anticholinergic medication increases risk of urinary retention & severe constipation**
  May lead to paralytic ileus

*** Buprenorphine; †Pentazocine, nalbuphine, butorphanol**

Drug Information Common to This Class

Use in opioid-tolerant patients

- See individual PI for products which:
  - Have strengths or total daily doses only for use in opioid-tolerant patients
  - Are only for use in opioid-tolerant patients at all strengths

Contraindications

- Significant respiratory depression
- Acute or severe asthma in an unmonitored setting or in absence of resuscitative equipment
- Known or suspected paralytic ileus
- Hypersensitivity (e.g., anaphylaxis)
- See individual PI for additional contraindications

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Pearls for Practice

Patients MUST be opioid-tolerant in order to safely take most ER/LA opioid products

Be familiar with drug-drug interactions, pharmacokinetics and pharmacodynamics of ER/LA opioids

Central nervous system depressants (alcohol, sedatives, hypnotics, tranquilizers, tricyclic antidepressants) can have a potentiating effect on the sedation and respiratory depression caused by opioids.

Optional Slide

Challenge: The Patient in the ER

Red Flag:

As a PCP you are woken by a telephone call at 2 am reporting that your patient, Mr. Diallo, is in the ER with apparent respiratory depression.

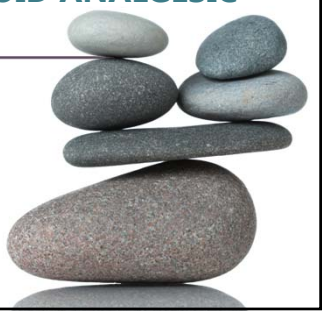
Action:

As the ED physician treating this patient, Did you make that call?

1. Be familiar with risk factors for respiratory depression and know when opioids are contra-indicated. Anticipate possible risks and develop contingency plans. Teach patients, family, and caregivers about respiratory depression and its symptoms.
2. Know that HIPPA excludes the gathering of information during the medical screening exam, if necessary to treat patient.

SPECIFIC DRUG INFORMATION FOR ER/LA OPIOID ANALGESIC PRODUCTS

Unit VI



Specific Characteristics

Know for opioid products you prescribe:

Drug substance	Formulation	Strength	Dosing interval
Key instructions	Use in opioid-tolerant patients	Product-specific safety concerns	Relative potency to morphine
Specific information about product conversions, if available		Specific drug interactions	

For detailed information, refer to online PI:
DailyMed at www.dailymed.nlm.nih.gov Drugs@FDA at www.fda.gov/drugsatfda

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Morphine Sulfate ER Capsules (Avinza)

Dosing interval	• Once a day
Key instructions	• Initial dose in opioid non-tolerant patients is 30 mg • Titrate in increments of not greater than 30 mg using a minimum of 3-4 d intervals • Swallow capsule whole (do not chew, crush, or dissolve) • May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing; use immediately • MDD:* 1600 mg (renal toxicity of excipient, fumaric acid)
Drug interactions	• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose • P-gp* inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	• 90 mg & 120 mg capsules for use in opioid-tolerant patients only
Product-specific safety concerns	• None

* MDD=maximum daily dose; P-gp= P-glycoprotein

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Buprenorphine Transdermal System (Butrans)

Dosing interval	• One transdermal system every 7 d

Key instructions	• Initial dose in opioid non-tolerant patients on <30 mg morphine equivalents & in mild-moderate hepatic impairment: 5 mcg/h
	• When converting from 30 mg-80 mg morphine equivalents, first taper to 30 mg morphine equivalent, then initiate w/ 10 mcg/h
	• Titrate in 5 or 10 mcg/h increments by using no more than 2 patches of the 5 or 10 mcg/h system(s) w/ minimum of 72 h prior between dose adjustments. Total dose from all patches should be ≤20 mcg/h
	• Maximum dose: 20 mcg/h due to risk of QTc prolongation
	• Application
	  • Apply only to sites indicated in PI
	  • Apply to intact/non-irritated skin
	  • Prep skin by clipping hair; wash site w/ water only
	  • Rotate application site (min 3 wks before reapply to same site)
	  • Do not cut
	• Avoid exposure to heat
	• Dispose of patches: fold adhesive side together & flush down toilet

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Buprenorphine Transdermal System (Butrans) cont'd

Drug interactions	• CYP3A4 inhibitors may increase buprenorphine levels • CYP3A4 inducers may decrease buprenorphine levels • Benzodiazepines may increase respiratory depression • Class IA & III antiarrythmics, other potentially arrhythmogenic agents, may increase risk of QTc prolongation & torsade de pointe
Opioid-tolerant	• 7.5 mcg/h, 10 mcg/h, 15 mcg/h, & 20 mcg/h for use in opioid-tolerant patients only
Drug-specific safety concerns	• QTc prolongation & torsade de pointe • Hepatotoxicity • Application site skin reactions
Relative potency: oral morphine	• Equipotency to oral morphine not established

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Methadone Hydrochloride Tablets (Dolophine)

Dosing interval	• Every 8 to 12 h
Key instructions	• Initial dose in opioid non-tolerant patients: 2.5 to 10 mg • Conversion of opioid-tolerant patients using equianalgesic tables can result in overdose & death. Use low doses according to table in full PI • Dosage adjustments using a minimum of 1-2 d intervals • High inter-patient variability in absorption, metabolism, & relative analgesic potency • Opioid detoxification or maintenance treatment only provided in a federally certified opioid (addiction) treatment program (CFR, Title 42, Sec 8)
Drug interactions	• Pharmacokinetic drug-drug interactions w/ methadone are complex – CYP 450 inducers may decrease methadone levels – CYP 450 inhibitors may increase methadone levels – Anti-retroviral agents have mixed effects on methadone levels • Potentially arrhythmogenic agents may increase risk for QTc prolongation & torsade de pointe • Benzodiazepines may increase respiratory depression

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Methadone Hydrochloride Tablets (Dolophine)

NOTE: While the dosing information below reflects the 8/20/14 FDA Blue Print, the CO*RE Expert Clinical Faculty believe it to be too aggressive and perhaps a risky approach. CO*RE Expert Clinical Faculty discourages methadone for opioid naive patients as an initial drug and recommends 4-5 d intervals for dosing adjustments.

Dosing interval	• Every 8 to 12 h
Key instructions	• Initial dose in opioid non-tolerant patients: 2.5 – 10 mg • Conversion of opioid-tolerant patients using equianalgesic tables can result in overdose & death. Use low doses according to table in full PI • Dosage adjustments using a minimum of *1-2 d intervals* • High inter-patient variability in absorption, metabolism, & relative analgesic potency • Opioid detoxification or maintenance treatment only provided in a federally certified opioid (addiction) treatment program (CFR, Title 42, Sec 8)
Drug interactions	• Pharmacokinetic drug-drug interactions w/ methadone are complex – CYP 450 inducers may decrease methadone levels – CYP 450 inhibitors may increase methadone levels – Anti-retroviral agents have mixed effects on methadone levels • Potentially arrhythmogenic agents may increase risk for QTc prolongation & torsade de pointe • Benzodiazepines may increase respiratory depression

FDA. *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics.* 08/2014. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM011290.pdf

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Methadone Hydrochloride Tablets (Dolophine) cont'd

Opioid-tolerant	• Refer to full PI
Drug-specific safety concerns	• QTc prolongation & torsade de pointe • Peak respiratory depression occurs later & persists longer than analgesic effect • Clearance may increase during pregnancy • False-positive UDT possible
Relative potency: oral morphine	• Varies depending on patient's prior opioid experience

Fentanyl Transdermal System (Duragesic)

12, 25, 37.5*, 50, 62.5*, 75, 87.5*, and 100 mcg/hr
(*These strengths are available only in generic form)

Dosing interval	• Every 72 h (3 d)
Key instructions	• Use product-specific information for dose conversion from prior opioid • Hepatic or renal impairment: use 50% of dose if mild/moderate, avoid use if severe • Application – Apply to intact/non-irritated/non-irradiated skin on a flat surface – Prep skin by clipping hair, washing site w/ water only – Rotate site of application – Titrate using a minimum of 72 h intervals between dose adjustments – Do not cut • Avoid exposure to heat • Avoid accidental contact when holding or caring for children • Dispose of used/unused patches: fold adhesive side together & flush down toilet

Fentanyl Transdermal System (Duragesic), cont'd

Key instructions	**Specific contraindications:** • Patients who are not opioid-tolerant • Management of – Acute or intermittent pain, or patients who require opioid analgesia for a short time – Post-operative pain, out-patient, or day surgery – Mild pain
Drug interactions	• CYP3A4 inhibitors may increase fentanyl exposure • CYP3A4 inducers may decrease fentanyl exposure • Discontinuation of concomitant CYP P450 3A4 inducer may increase fentanyl plasma concentration
Opioid-tolerant	• All doses indicated for opioid-tolerant patients only
Drug-specific safety concerns	• Accidental exposure due to secondary exposure to unwashed/unclothed application site • Increased drug exposure w/ increased core body temp or fever • Bradycardia • Application site skin reactions
Relative potency: oral morphine	• See individual PI for conversion recommendations from prior opioid

Morphine Sulfate ER-Naltrexone Tablets (Embeda)

Dosing interval	• Once a day or every 12 h
Key instructions	• Initial dose as first opioid: 20 mg/0.8 mg • Titrate using a minimum of 1-2 d intervals • Swallow capsules whole (do not chew, crush, or dissolve) • Crushing or chewing will release morphine, possibly resulting in fatal overdose, & naltrexone, possibly resulting in withdrawal symptoms • May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately
Drug interactions	• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose • P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	• 100 mg/4 mg capsule for use in opioid-tolerant patients only
Product-specific safety concerns	• None

Hydromorphone Hydrochloride ER Tablets (Exalgo)

Dosing interval	• Once a day
Key instructions	• Use conversion ratios in individual PI • Start patients w/ moderate hepatic impairment on 25% dose prescribed for patient w/ normal function • Renal impairment: start patients w/ moderate on 50% & patients w/ severe on 25% dose prescribed for patient w/ normal function • Titrate in increments of 4-8 mg using a minimum of 3-4 d intervals • Swallow tablets whole (do not chew, crush, or dissolve) • Do not use in patients w/ sulfite allergy (contains sodium metabisulfite)
Drug interactions	• None
Opioid-tolerant	• All doses are indicated for opioid-tolerant patients only
Product-specific adverse reactions	• Allergic manifestations to sulfite component
Relative potency: oral morphine	• ~5:1 oral morphine to hydromorphone oral dose ratio, use conversion recommendations in individual product information

Morphine Sulfate ER Capsules (Kadian)

Dosing interval	• Once a day or every 12 h
Key instructions	• PI recommends not using as first opioid • Titrate using minimum of 2-d intervals • Swallow capsules whole (do not chew, crush, or dissolve) • May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately
Drug interactions	• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose of morphine • P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	• 100 mg & 200 mg capsules for use in opioid-tolerant patients only
Product-specific safety concerns	• None

Hydrocodone Bitartrate (Hysingla ER)

Extended–Release Tablets, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg, and 120

Dosing interval	• Once a day
Key instructions	• Opioid-naïve patients: initiate treatment with 20 mg orally once daily. • During titration, adjust the dose in increments of 10 mg to 20 mg every 3 to 5 days until adequate analgesia is achieved. • Swallow tablets whole (do not chew, crush, or dissolve). • Consider use of an alternative analgesic in patients who have difficulty swallowing or have underlying gastrointestinal disorders that may predispose them to obstruction. • Take one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth. • Use 1/2 of the initial dose and monitor closely for adverse events, such as respiratory depression and sedation, when administering Hysingla ER to patients with severe hepatic impairment or patients with moderate to severe renal impairment.

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Hydrocodone Bitartrate (Hysingla ER),

Drug interactions	• CYP3A4 inhibitors may increase hydrocodone exposure. • CYP3A4 inducers may decrease hydrocodone exposure. • Concomitant use of Hysingla ER with strong laxatives (e.g., Lactulose) that rapidly increase GI motility may decrease hydrocodone absorption and result in decreased hydrocodone plasma levels. • The use of MAO inhibitors or tricyclic antidepressants with Hysingla ER may increase the effect of either the antidepressant or Hysingla ER.
Opioid-tolerant	• 80 mg is only for use in opioid tolerant patients.
Drug-specific safety concerns	• Use with caution in patients with difficulty swallowing the tablet or underlying gastrointestinal disorders that may predispose patients to obstruction. • Esophageal obstruction, dysphagia, and choking have been reported with Hysingla ER. • In nursing mothers, discontinue nursing or discontinue drug. QTc prolongation has been observed with Hysingla ER following daily doses of 160 mg. • Avoid use in patients with congenital long QTc syndrome. This observation should be considered in making clinical decisions regarding patient monitoring when prescribing Hysingla ER in patients with congestive heart failure, bradyarrhythmias, electrolyte abnormalities, or who are taking medications that are known to prolong the QTc interval. • In patients who develop QTc prolongation, consider reducing the dose.
Relative potency: oral morphine	• See individual PI for conversion recommendations from prior opioid

Morphine Sulfate ER Capsules (Kadian)

Dosing interval	• Once a day or every 12 h
Key instructions	• PI recommends not using as first opioid • Titrate using minimum of 2-d intervals • Swallow capsules whole (do not chew, crush, or dissolve) • May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately
Drug interactions	• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose of morphine • P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	• 100 mg & 200 mg capsules for use in opioid-tolerant patients only
Product-specific safety concerns	• None

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Morphine Sulfate CR Tablets (MS Contin)

Dosing interval	• Every 8 h or every 12 h
Key instructions	• Product information recommends not using as first opioid. • Titrate using a minimum of 1-2 d intervals • Swallow tablets whole (do not chew, crush, or dissolve)
Drug interactions	• P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	• 100 mg & 200 mg tablet strengths for use in opioid-tolerant patients only
Product-specific safety concerns	• None

Tapentadol ER Tablets (Nucynta ER)

Dosing interval	• Every 12 h
Key instructions	• 50 mg every 12 h is initial dose in opioid non-tolerant patients • Titrate by 50 mg increments using minimum of 3-d intervals • MDD: 500 mg • Swallow tablets whole (do not chew, crush, or dissolve) • Take 1 tablet at a time w/ enough water to ensure complete swallowing immediately after placing in mouth • Dose once/d in moderate hepatic impairment (100 mg/d max) • Avoid use in severe hepatic & renal impairment
Drug interactions	• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of a potentially fatal dose of tapentadol • Contraindicated in patients taking MAOIs
Opioid-tolerant	• No product-specific considerations
Product-specific safety concerns	• Risk of serotonin syndrome • Angio-edema
Relative potency: oral morphine	• Equipotency to oral morphine has not been established

Oxymorphone Hydrochloride ER Tablets (Opana ER)

Dosing interval	• Every 12 h dosing, some may benefit from asymmetric (different dose given in AM than in PM) dosing
Key instructions	• Use 5 mg every 12 h as initial dose in opioid non-tolerant patients & patients w/ mild hepatic impairment & renal impairment (creatinine clearance <50 mL/min) & patients >65 yrs • Swallow tablets whole (do not chew, crush, or dissolve) • Take 1 tablet at a time, w/ enough water to ensure complete swallowing immediately after placing in mouth • Titrate in increments of 5-10 mg using a minimum of 3-7 d intervals • Contraindicated in moderate & severe hepatic impairment
Drug interactions	• Alcoholic beverages or medications w/ alcohol may result in absorption of a potentially fatal dose of oxymorphone
Opioid-tolerant	• No product-specific considerations
Product-specific safety concerns	• Use with caution in patients who have difficulty swallowing or underlying GI disorders that may predispose to obstruction (e.g. small gastrointestinal lumen)
Relative potency: oral morphine	• Approximately 3:1 oral morphine to oxymorphone oral dose ratio

Oxycodone Hydrochloride CR Tablets (OxyContin)

Dosing interval	• Every 12 h
Key instructions	• Initial dose in opioid non-tolerant patients: / 10 mg every 12 h • Titrate using a minimum of 1-2 d intervals • Hepatic impairment: start w/ ⅓-½ usual dosage • Renal impairment (creatinine clearance <60 mL/min): start w/ ½ usual dosage • Consider other analgesics in patients w/ difficulty swallowing or underlying GI disorders that predispose to obstruction. Swallow tablets whole (do not chew, crush, or dissolve) • Take 1 tablet at a time, w/ enough water to ensure complete swallowing immediately after placing in mouth
Drug interactions	• CYP3A4 inhibitors may increase oxycodone exposure • CYP3A4 inducers may decrease oxycodone exposure
Opioid-tolerant	• Single dose >40 mg or total daily dose >80 mg for use in opioid-tolerant patients only
Product-specific safety concerns	• Choking, gagging, regurgitation, tablets stuck in throat, difficulty swallowing tablet • Contraindicated in patients w/ GI obstruction
Relative potency: oral morphine	• Approximately 2:1 oral morphine to oxycodone oral dose ratio

Oxycodone Hydrochloride/Naloxone Hydrochloride ER Tablets (Targiniq ER)

Dosing interval	• Every 12 h
Key instructions	• Opioid-naïve patients: initiate treatment w/ 10mg/5mg every 12 h • Titrate using min of 1-2 d intervals • Do not exceed 80 mg/40 mg total daily dose (40 mg/20 mg q12h) • May be taken w/ or without food • Swallow whole. Do not chew, crush, split, or dissolve: this will release oxycodone (possible fatal overdose) & naloxone (possible withdrawal) • Hepatic impairment: contraindicated in moderate-severe impairment. In patients w/ mild impairment, start w/ ⅓-½ usual dosage • Renal impairment (creatinine clearance <60 mL/min): start w/ ½ usual dosage
Drug interactions	• CYP3A4 inhibitors may increase oxycodone exposure • CYP3A4 inducers may decrease oxycodone exposure
Opioid-tolerant	• Single dose >40 mg/20 mg or total daily dose of 80 mg/40 mg for opioid-tolerant patients only
Product-specific safety concerns	• Contraindicated in patients w/ moderate-severe hepatic impairment
Relative potency: oral morphine	• See individual PI for conversion recommendations from prior opioids

Hydrocodone Bitartrate ER Capsules (Zohydro ER)

Dosing interval	• Every 12 h
Key instructions	• Initial dose in opioid non-tolerant patient is 10 mg • Titrate in increments of 10 mg using a min of 3-7 d intervals • Swallow capsules whole (do not chew, crush, or dissolve)
Drug interactions	• Alcoholic beverages or medications containing alcohol may result in rapid release & absorption of a potentially fatal dose of hydrocodone • CYP3A4 inhibitors may increase hydrocodone exposure • CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	• Single dose >40 mg or total daily dose >80 mg for use in opioid-tolerant patients only
Product-specific safety concerns	• None
Relative potency: oral morphine	• Approximately 1.5:1 oral morphine to hydrocodone oral dose ratio

Summary

Prescription opioid abuse & overdose is a national epidemic. Clinicians must play a role in prevention

- Understand how to assess patients for treatment w/ ER/LA opioids
- Be familiar w/ how to initiate therapy, modify dose, & discontinue use of ER/LA opioids
- Know how to manage ongoing therapy w/ ER/LA opioids
- Know how to counsel patients & caregivers about the safe use of ER/LA opioids, including proper storage & disposal
- Be familiar w/ general & product-specific drug information concerning ER/LA opioids

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IMPORTANT!

Thank you for completing the post-activity assessment for this CO*RE session.

Your participation in this assessment allows CO*RE to report de-identified numbers to the FDA.

A strong show of engagement will demonstrate that clinicians have voluntarily taken this important education and are committed to patient safety and improved outcomes.

THANK YOU!

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Thank you!

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