Safe Prescribing of Controlled Medications

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Deborah Hopla, Disclosures

- Dr. Hopla has no conflicts or interests or disclosures relevant to the content of this presentation.
- Dr. Hopla does work in pain management one day a week at a FQHC.
- This content may include discussion of off label or investigative drug uses. The presenter will disclose this information when this is presented.

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Objectives

- At the conclusion of this activity participants should be able to:
- Analyze and assess patients that require controlled medication prescriptions.
- Evaluate and identify current Evidence-based Practice in the treatment of patients requiring controlled medications including current laws for prescribing.
- Comprehend the broad scope of practice and responsibilities for better patient outcomes when prescribing controlled medications.

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Why is this Topic Important?

- Everyday in practice we encounter patients that are **suffering.**
- Not every educational program teaches providers how to handle the patient's complex needs using Evidence-Based Practice.
- Not everyone is aware of the current laws.
- Every provider has concerns of harming a patient.
- No one wants to risk losing their license and go to jail!

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The Balancing Act

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The Problem in Practice

- **In the September 14, 2018 the CDC reported in Morbidity and Mortality Weekly (MMW) that studies have estimated the prevalence of chronic pain to range from 11% to 40%.**
- **In 2016: 20.4% or >50 million people had chronic pain.**
- **In 2016: 8.0% of U.S. Adults (19.6 million) reported high impact chronic pain.**

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The Problem in Practice

- The same MMW study revealed chronic pain issues were more prevalent among:
- Non-Hispanic Whites,
- Adults living in poverty,
- Women more than men,
- Less than a high school education,
- Aging populations (greater than 65 years old), and
- Adults on public health insurance (Including Medicare, Medicaid, and The Veterans Administration).

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Current Problem

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The Problem

- In 2017 more than 191 million opioid prescriptions were dispensed to American patients.
- Alabama wrote three times as many prescriptions.
- Hawaii wrote the least number of prescriptions.
- Large cities have had a 54% increase in opioid overdoses.
- Is this because of the health status of the populations?
- Is this an availability issue?
- Is it do to the providers knowledge?
- Is it a comorbid factor?

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The Problem in South Carolina

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The National Institute on Drug Abuse (March 2019)

- In 2017 there were 749 overdose deaths in SC (15.5 deaths per 100,00 persons)with the national rate of 14.6 per 100,000.
- The greatest increase in death rates were among synthetic opioids (fentanyl).

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CDC Opioid Death Information, March, 2018

- The **three most common drugs involved in opioid deaths**:
- Methadone
- Oxycodone
- Hydrocodone
- Heroin deaths have increased from 19 deaths in 2012 to 153 deaths in 2017.

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Reality

- Per the National Institute on Drug Abuse (March, 2019) in 2017 providers wrote 79.3 opioid prescriptions for every 100 persons.
- This compares to only 58.7 per 100 prescriptions in the U.S.
- This is a decline of 12% in SC opioid prescriptions since 2006.
- The death rate of overdoses remains unchanged overall with 7.1 deaths per 100,000 persons.

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Economic Impact

- Per MMW, March 2017, chronic pain contributes an estimated **$560 billion annually** in direct medical costs, loss of productivity, and disability.

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APRN Laws for Controlled Medications in SC

- Under the SC Nurse Practice Act (2018), APRN may use prescriptive authority to prescribe or write orders for controlled medications in Schedule II-V.
- C-II narcotics may be prescribed:
- For **five days only** and another prescription must not be written without the written agreement by the physician with whom the nurse practitioner has entered into a collaborative practice agreement, unless the prescription is written for patients in **hospice or palliative care.**
- **C-II controlled non-narcotics medications** can be prescribed for **30 days and for each renewal.**

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APRN Laws for Controlled Medications in SC

- The Department of Health and Environmental Control (DHEC) H. 3728/65 states that the provider (or designated delegate) writing controlled medications for patients must review the history of controlled substance prescription history on the Prescription Monitoring Program (PMP).
- On the PMP there is an overdose risk score with information of prescribed controlled medications, prescribers of the medications, location of the prescribers and the various pharmacy and location of the pharmacies.
- If a person is administered an opioid antidote this must be reported to the DHEC Bureau of Drug Control.

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APRN Laws for Controlled Medications in SC

- Examples of **C II-C V (examples and not all inclusive lists)**:
- **Examples of C-II medications**: Hydromorphone (Dilaudid), methadone (Dolophine), meperidine (Demerol), oxycodone (OxyContin, Percocet, Nalocet: A combination of oxycodone and Acetaminophen), hydrocodone (Zohydro ER, and combinations with acetaminophen) and fentanyl (Sublimaze, Duragesic). Other Schedule II narcotics include: Morphine, opium, and codeine.

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APRN Laws for Controlled Medications in SC

- **Examples of Schedule II stimulants**: Amphetamine (Dexedrine, Adderall,) methamphetamine (Desoxyn), and methylphenidate (Ritalin).
- **Examples of C III medications**: Buprenorphine (Suboxone, Belbuca film), Tylenol with Codeine).
- **Non-narcotics include**: Benzphetamine (Didrex), phendimetrazine, ketamine, and anabolic steroids such as Depo-Testosterone.

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APRN Laws for Controlled Medications in SC

- **Examples of C IV medications**: Alprazolam (Xanax), carisoprodol (Soma), clonazepam (Klonopin), clorazepate (Tranxene), diazepam (Valium), lorazepam (Ativan), midazolam (Versed), temazepam (Restoril), and triazolam (Halcion).
- **Examples of C V medications:** Cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC, Phenergan with Codeine), and ezogabine (anti-seizure medication).

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Let's start at the beginning!

- Some Vital Information:
- Using a template: Builds a picture, adds a logical progression and ensures you will not miss any key components.
- Some like to use OLD CARTS: The onset of symptoms, location of/radiation, duration, character, aggravating factors, alleviating factors, timing, and severity.

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Another Way!

- **S.C.R.I.P.T. Template** for History:
- **Story**-Onset, Location, Timing, Mechanism of Injury, Details
- **Current Symptoms**: location, Description, ROM, Aggravating/Alleviation of Symptoms.

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SCRIPTS History

- **Relevant Medications**: Does the patient **Now** or **Ever** taken:
  Muscle relaxers, Neuromodulators, Antidepressants, Opioids,
  Benzodiazapems, OTC pain relievers. Which ones and dosages.

Be sure to include allergies and noted reactions.

Interventions: What was the intervention? What structure was injected? What medications were used? Was this a diagnostic or a therapeutic injection

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SCRIPTS

- **Physical Therapy:** When? How long? How often? How long?
  What type of PT? If they improved are they still doing PT?
  Did it make things worse?

Tests: Imaging? MRI, X-Ray, CT, Ultrasound?

Stuff from OTC: Creams, Ointments, TENS units, herbals, and any adjunct therapies Like teas, and diets.

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Important Terms

- **Acute Pain**: Is pain that starts suddenly and has a known cause like an injury, or surgery. It lasts less than three months.
- **Chronic Pain**: Is a pain that lasts longer than three months and can be due to a known disease, condition, injury, inflammation, or an unknown reason.
- **Drug Addiction**: Is now referred to as Substance Use (Abuse) Disorder or Opioid Use Disorder **(OUD)**.

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Important Terms

- **Physical Dependence**: There are symptoms of withdrawal when the drug is stopped.
- **Tolerance:** when more medication is needed due to arriving at a threshold and additional medication is required to achieve the same outcome.
- **Opiates:** Refer to natural opioids like: Heroin, Morphine, and Codeine.
- **Opioids**: Refers to all natural, semisynthetic, and synthetic opioids.

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The CDC Guidelines for Treatment of Chronic Pain

- **Use nonopioid therapies first**: Like Acetaminophen, NSAIDS, Topicals (NSAIDS and Capsaicin).
- Identify and address co-existing mental health conditions (like depression, anxiety, post-traumatic stress disorder, and adverse childhood events (ACE).
- Use a **TEAM** approach to patients: Behavioral health counselors, psychologists, psychiatrists, chiropractors, physical therapists, occupational therapists, message therapists, pain specialists, and pain interventionists.

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The CDC Guidelines for Treatment of Chronic Pain

- Focus on goals and improvements: Set Realistic goals for pain and function.
- Discuss benefits and risks.
- Evaluate the risk of harm or misuse.
- Set Criteria for stopping or continuing opioids.
- Use disease specific treatments when available (triptans for migraines, gabapentin/pregababalin/duloxetine for neuropathic pain), biologics as indicated.

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The CDC Guidelines for Treatment of Chronic Pain

- Consider Interventional Therapies: Tigger points, dry needle injections, ESI, Intra-articular joint injections with glucocorticoid injections or hyaluronic acid into knees.
- **Reassess** within a couple of weeks.
- Go through the **SCRIPTS/OLDCARTS to reassess**.
- Paint a picture. "What does the addition of the pain medication allow you to do that you could not do before this addition?"
- Refer to a Pain Management Specialty Practice.

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CDC Guidelines for Chronic Pain Management

- www.cdc.gov/drugoverdose/prescribing/guidelines.html

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AAFP/CDC Guidelines

- The American Academy of Family Practice (AAFP) in May, 2019 warned that the guidelines by the CDC are just that "Guidelines" and should not be interpreted as "Standards of Care" because "they do not take into account patients with cancer, acute sickle cell crisis, or post-surgical pain." They also point out there are times patients will need to exceed the 90 MME (Morphine Milligram Equivalents)" and this dosage has been given as a threshold for prevent accidental overdosing.

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Considerations

- Rapid Tapers, or abrupt discontinuation of opioids in dependent patients could precipitate opioid withdrawal. And be very dangerous for patients.
- Try to keep patients at the lowest does possible based on evidence:
- Does it help the patient function? Being "Pain free" is NOT realistic, but being functional is realistic.
- Is the patient compliant?
- Does the PMP Scripts Profile reveal any warning signs?
- Is the patient in a TEAM approach program?

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Screening Tools

- Some short patient Self-Assessment Tools to assist in identifying patients at risk:
- PHQ-9
- GAD-7
- Brief Risk Questionnaire
- CAGE
- ACE

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PHQ-9

- **Over the last two weeks, how often have you been bothered by the following problems?**
- **Not at all=0**
- **Several Days=1**
- **More than half of the days=2**
- **Nearly every day=3**

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PHQ-9 Questions

- 1. Little interest or pleasure in doing things.
- 2. Feeling down, depressed, or hopeless.
- 3. Trouble falling asleep or staying asleep, or sleeping too much.
- 4. Feeling tired or having little energy.
- 5. Poor appetite or overeating.
- 6. Feeling bad about yourself-or that you are a failure or have let your self or your family down.

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PHQ-9 Questions

- 7. Trouble concentrating on things, such as reading the newspaper or watching television.
- 8. Moving or speaking so slowly that other people have noticed. Or, fidgety or restless and moving around a lot more than usual.
- 9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way.

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GAD-7

- **Same grading scale as the PHQ-9**
- 1. Feeling nervous, anxious, or on edge
- 2. No being able to sleep or control worrying.
- 3. Worrying too much about different things.
- 4. Trouble relaxing.
- 5. Being so restless that it is hard to sit still.
- 6. Becoming easily annoyed or irritable.
- 7. Feeling afraid, as if something awful might happen.

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Brief Risk Questionnaire

- 1. Have you EVER been discharged from a medical practice? Y/N
- 2. How often have you ever had to take more pain medications that you were suppose to take? **Never/A Few Times/Several Times/ Many Times**
- 3. How often have you ever had to get pain medication from family, friends, or the street? **Never/A Few Times/Several Times/ Many Times**
- 4. How depressed would you say you are now? Not depressed/A Little Depressed/ Moderately Depressed/ Very Depressed

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Brief Risk Questionnaire

- 5. How nervous and worried would you say you are now? **Not Anxious/A Little Anxious/Moderately Anxious/Very Anxious**
- **6.** Have you EVER been diagnosed with Bipolar Disorder OR Attention Deficit Disorder (ADD/ADHD)? **Y/N**
- **7.** Has any of your pain medications ever been stolen? **Y/N**
- 8. Have you ever had a drinking or drug abuse problem? **Y/N**
- **9.** Did your biological parents have an alcohol or drug problem? Y/N

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Brief Risk Questionnaire

- 10. Have you ever had to spend time in jail or prison? **Y/N**
- 11. How is your reading ability**? Can't read/Poor Reader/ Read OK or Well**
- **12. Does someone help you with storing or taking your pain medications?** Y/N

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Health Assessment Questionnaire

- Answer the following Questions with the following Scoring:
- **Without Difficulty=0**
- **With SOME Difficulty=1**
- **With MUCH Difficulty=2**
- **Unable to DO=3**

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Health Assessment Questionnaire

- Over the LAST WEEK, were you able to:
- 1. Dress yourself, including tying your shoelaces and doing buttons?
- 2. Get in and out of be?
- 3. Lift a cup or glass to your mouth?
- 4. Walk outdoors on the flat ground?
- 5. Wash and dry your entire body?
- 6. Bend down and pick up clothing from the floor?
- 7. Turn regular faucets off and on?

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Health Assessment Questionnaire

- 8. Get in and out of a car, bus, train, or airplane?
- 9. Walk two miles if you wish?
- 10. Participate in recreational activities and sports as you would like?
- 11. Get a good night's sleep?
- 12. Deal with feelings of anxiety or being nervous?
- 13. Deal with feelings of depression or feeling blue?

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Health Assessment Questionnaire

- On a scale from 0-10 with 0= no pain and 10 pain as bad as it can be how severe is your pain?
- Considering all the ways in which illness and health conditions may affect you at this time from 0-10 with 0=Very Well and 10 Very poorly. Tell me how you think you are doing.

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CAGE-AID

- 1. Have you ever felt that you should cut down on your drinking or drug use? **Y?N**
- 2. Have people annoyed you by criticizing your drinking or drug use? **Y/N**
- 3. Have you ever felt bad or guilty about your drinking or drug use? **Y/N**
- 4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? **Y/N**

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Adverse Childhood Events (ACE).

- This questionnaire deals with:
- Abuse
- Neglect
- Dysfunction
- A score above 4 relates to a higher incidence of drug use and abuse.
- Women with fibromyalgia report **60% of trauma**.
- Relates strongly to Chronic Overlapping Pain Syndrome (COPS) fibromyalgia, IBS, ICS, vulvodynia, endometriosis TMJ, Chronic back pain, chronic migraine, daily headaches, Chronic fatigue syndrome.

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ACE Score: A Yes =1 Point

- 1. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you, or act in a way that made you feel afraid that you might be physically hurt?
- 2. Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you? Were you ever hit so that it left marks or you were physically injured?
- 3. Did an adult or person at least 5 years older than you ever, touch or fondle you or have you touch their body in sexual ways, or attempt or actually have oral, anal, or vaginal intercourse with you?

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ACE Score: A Yes =1 Point

- 4. Did you often or very often feel that no one in your family loved you or thought you were important or special or feel that your family did not look out for each other, feel close to each other, or support each other?
- 5. Did you often or very often feel that you did not have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
- 6. Was a biological parent ever lost to you through divorce, abandonment, or other reason?

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ACE Score: A Yes =1 Point

- 7. Did you see your Mother or Stepmother have someone often or very often pushed, grabbed, slapped, or had something thrown at them or sometimes, often, or sometimes, very often or often kicked, bitten, hit with a fist, or hit with something hard, or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
- 8. Did you ever live with anyone who was a problem drinker or alcoholic, or used street drugs?
- 9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
- 10. Did a household member go to prison?

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Pain Contracts

- Vital Information:
- **Establish a pain Contract with the patient!**

- **OVERALL STATEMENT:**

The purpose of this Agreement is to provide a clear understanding about certain medications you will be taking for pain, and other conditions that require the use of controlled substances such as opiates, opioids, stimulants, or anti-anxiety medications. This is to help both you and your provider comply with the law regarding controlled medications.

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Contracts

- Include Items like:
- An understanding that the agreement is essential to trust and confidence in the provider/patient relationship.
- Notify the provider if or when they become involved in any drug replacement therapy program like: Methadone, Suboxone.
- Keep all scheduled appointments.
- An understanding that prescriptions are only written at the time of a visit.

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Contracts

- All medications have the potential for addiction, side effects, and cravings. The patient agrees to notify the provider of an side effects, cravings or suspected addiction.
- Staff and providers will be treated respectfully. Failure to do so could result in dismissal.
- No other provider will be writing for controlled medications, and this includes: Stimulants, pain medications, and/or anti-anxiety agents.
- The treatment goal is to improve my quality of life and function.

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Contracts

- Lost or stolen medications will NOT be replaced!
- Only the following pharmacy will be used to fill my prescriptions:_____.
- I understand my provider and my pharmacy will cooperate with any city, state, and/or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of medications.
- I agree to drug testing and possible counting of pills and must present within 24 hours of being contracted for testing and/or counting.

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Contracts

- I will not use my medications at a greater rate than being prescribed. I could be a at risk for withdrawal and dismissal from the treatment program.
- I agree that I will NOT sale, trade or share my medications with anyone.
- I agree to NOT use any illegal substances.
- I understand if I break any portion of this agreement I will not be prescribed controlled medications and may be discharged from the practice.

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Urine Drug Screens

- Urine drug screens test in the office as a “quick dip” are easy to collect, and cost-effective. Be aware there are a large number of false positives and negatives.
- The urine drug screen should measure temperature, specific gravity and creatinine.
- A Gas Chromatography/mass spectrometry (GC/MS) can confirm the presence or absence of a specific drug and its metabolites.

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Urine Drug Screens

- While urine drug screens and help assist you making decisions about appropriate prescribing, remember to include the patient in the discussions of the results.
- Document the test results in the chart and any discussions with the patient in the medical record.
- Remember the test is a clinical test NOT a forensic test. **When in doubt "Send It out!"**

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Drug Metabolites, Cut-off levels, Time and Detection: Urine DS

DRUG	METABOLITE	CUT-OFF	POTENTAL SOURCE of FALSE POSITIVE	TIME for DETECTION
Opiates	Morphine	300-2,000	Poppy Seeds Rifampin Chloropromazine Dextromethorphan	2-4 Days

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Drug Metabolites, cut-off levels, Time and Detection: Urine DS

DRUG	METABOLITE	CUT-OFF	POTENTIAL SOURCE for FALSE POSITIVE	DETECTION TIME
Cocaine	Benzoylecogine	300	VERY SPECIFIC Metabolite	2-4 days

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Drug Metabolites, Cut-off levels, Time and Detection: Urine DS

DRUG	METABOLITE	CUT-OFF	POTENTIAL SOURCE for FALSE POSITIVE	DETECTION TIME
Amphetamine Methamphhetamine	Amphetamine	1,000	Ephedrine Phenylpropanolamine Methylphenidate Trazadone Bupropion Ranitidine	2-4 Days

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Drug Metabolites, Cut-off levels, Time and Detection: Urine DS

DRUG	METABOLITE	CUT-OFF	POTENTIAL SOURCE of FALSE POSITIVE	DETECTION TIME
Marijuana	Tetrahydrocannabinol	50	NSAIDS Marinol Pantoprazole	1-3 days for intermittent use but > 50 days for chronic use
Benzodiazopines	Measures Oxazepam, and Diazepam but poorly detects newer agents.	200	Oxaprozin	Varies with each benzos half-life.

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Red Flags

- Recurrent early request for refills
- Lost or stolen medications
- Prescription Monitoring Program demonstrates multiple medications from multiple sources.
- Intoxication/Impairment.
- Pressuring/Threatening Behaviors

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Red Flags

- Documented drug diversion, prescription forgeries.
- Continued use of illicit drugs despite counselling.
- Random drug testing reveals a lack of prescribed medications.
- Deterioration of function.
- Failure to follow treatment plan.
- Failure to comply with pain contract.
- Overdosing, suicide attempts, arrests, and/or incarceration.

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Evaluate the Risk for Harm or Misuse

- Is there a history of substance use or abuse?
- Are there any mental health issues?
- Are there any sleep-disorders
- Is there concurrent use of benzodiazepines?
- Is the patient using illegal substances?

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Prescribing Opioids

- GO LOW GO SLOW!
- Ensure the patient has realistic expectations!
- Present opioids as a therapeutic trial or test for a defined period of time to access function and pain.
- Avoid prescribing opioids in a patient using benzodiazepines. Remember that SSRIs and SNRIs work well for most patients.
- Use immediate-release opioids when starting .
- Prescribe no more than needed.

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Prescribing Opioids

- **Do not prescribe ER/LA opioids for acute pain.**
- **Avoid prescribing greater than 90 MME/day.**
- **Use the Prescription Monitoring Program to follow patients.**
- **Assess the Overdose Risk Score and Document.**
- **Follow Evidence-Based Guidelines and recommended standards of care for treatment of conditions.**

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Hydrocodone

- Hysingia ER
- Dosage: 20mg/qd
- May increase 10-20 mg a day

- Zohydro ER 10mg q 12 hours
- May increase 10mg q 12 every 3-7 days

Other Names: Lortab, Vicodin

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Hydrocodone

- Generic: Cough 5 mg q 4 hours for a max dosage of 15 mg/day or 30 ml is 24 hours.
- 2.5mg-10 tablets q 4-6 hours.

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Hydrocodone/Acetaminophen

- Brand Names: Lorcet, Norco, Vicodin, Vicoden ES, Xodol and Generic
- 5/325
- 7.5/325
- 10/325

* Remember to caution the patient about the acetaminophen max dosage for 4000 mg/day.*

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Nucnta IR/ER

- IR Formulation: May prescribe 50-100 mg q 4-6 hours and may give the 2nd dose >1 hour after the first dose. Max. 700mg/day
- Day2 50-100 mg q 4-6 hours with a max of 600 mg.
- ER Formulation: May prescribe 50-100 mg q 12 hours.

* Do not use if the patient's CrCl < 30mL/m

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Hydromorphone

- Common Branded name: Dilaudid
- Formulations: PO, IV,
- Dosage 2-4mg q 4-6 hours for PO
- IV: 0.2-1 mg q 2-3 hours

*Not recommended IM

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Oxycodone

- Brand Names: Oxaydo, OxyContin, Roxicodone, Xtampza ER
- IR Formulation: 5-15 mg q 4-6 hours and may increase 5-20 mg a dose.
- ER Formulation: Start at 10mg q 12 and can increase to a max of 80 mg/day
- Capsules are start at 9 mg q 12 and increase to max of 72 mg/day.

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Oxycodone/Acetaminophen

- Common Names: Endocet, Percocet, Primlex, Xartemis XR, and Generic.
- Dosages: 1-2 tabs q 4-6 hours
- 5/325
- 10/325
- 20/325

* Remember the Acetaminophen max of 4000mg/day

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Morphine

- **Common Names: Arymo ER, Infumorph 200mg, 500mg. Kadin, Mitigo, MorhpaBond ER, MS Contin, Actiq, Fentora, Lazandra, Onsolis**
- **Dosage: PO 10 mg q 4 hours up to 30 mg q 4 for severe pain.**
- **IV: 1-4 mg q 1-4 hours**
- **Sickle Cell Crisis 0.1-0.15mg/kg**
- **Solution: 100mg/5ml: 5mg-30mg q 4 hours**
- **SQ: 2-5 mg q 2-4 hours**
- **ER Formulation: q 12 hours.**

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Tramadol

- **Common Names with Dosages:**
- Durela: 100mg, 200mg, 300mg
- ConZip: 100mg, 200 mg, 300mg
- Raliva: 100 mg, 200mg, 300 mg
- Tridiral: 100mg, 200mg, 300mg
- Ultram: 100mg, 150mg, 200mg, 300mg
- Ultram ER: 100mg, 200mg, 300mg
- Zytram XL 75 mg, 150 mg, 400mg

***Start all at 50mg q 4-6 hours up to a max of 400mg/day.**

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Ultracet

- Comes in 37.5/325
- 2 tabs q 4-6 hours up to a max of 8 tabs a day.

*Do not give > 5 days.

*If the patient's CrCl is < 30 then 2 tabs q 12 hours.

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Fentanyl

- Common Names and Dosages:
- Duragesic
- 12=12.5 mcg/hr
- 25=25 mcg/hr
- 50=50 mcg/hr
- 75=75 mcg/hr

Maintenance: 25-50 mcg/hr or 3.5-0.5 mcg/kg/hr.

***CAUTION:** the elderly are at two times the risk of sensitivity.

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Fentanyl

- Other Methods of Delivery: Powder Solution for Buccal Application
- Lozenges for Sublingual: Abstral: 100mcg, 200mcg, 300 mcg, 400mcg, 600mcg, 800mcg.
- Fentoral: 100mcg, 200mcg, 400 mcg, 600mcg, 800 mcg.

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Calculating Morphine Milligram Equivalents (MME)

- Determine the total daily amount of each opioid the patient is taking.
- Convert each to MMEs-Multiply the dose for each opioid by the conversion factor.
- Add the mg/day.
- **CAUTION**: Do not use the calculated dose in MMEs to determine converting one opioid to another-GO LOW GO SLOW and lower the newer opioid to avoid unintentional overdose caused by a tolerance or individual metabolizing the medication differently.

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Buprenorphine and Naloxone

- Names: Belbuca,Bunavail, Suboxone, Zubsolv,
- Need an X waiver to prescribe: 24 hours of continuing education for APRNS and listed in the practice agreement.
- Ensure there has been **NO** use of an opioid for a minimum of 5-7 days before using!
- Belbuca Dosages: 75, 150, 300 450,600, 900 mcg
- Dosed q 12 hours by 1. Wetting the inside of the cheek, pressing the yellow side to the cheek and hold down for 5 seconds with two fingers, press another finger oin the outside of the cheek to position the film, do NOT Chew or Swallow the film! Do not eat or drink anything for 30 minutes.

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Buprenorphine and Naloxone

See UpToDate for Prescribing per each product by name.

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Conversion Factor

OPIOID	CONVERSION FACTOR
CODEINE	0.15
FENTANYL (in mcg/hr)	2.4
HYDROMORPHONE	1

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Conversion Factor

OPIOID	CONVERSION FACTOR
HYDROCODONE	1
HYDROMORPHONE	4
METHADONE: See dosages below*	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
>60-80 mg/day	12

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Conversion Factor

OPIOID	CONVERSION FACTOR
MORPHINE	1
OXYCODONE	1.5
OXYMORPHONE	3

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CONVERSION

OPIOID	CONVERSION FACTOR
Tapentadol (Nucynta ER/IR)	0.4
Tramadol	0.1

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USING THE TOTAL OPIOID DOSE IN CLINICAL PRACTICE

- Start with prescribing the lowest dose to give the desired effect.
- Use additional caution when going over 50MMEs per day.
- Consider offering naloxone
- AVOID going over dosages >90 MME/day.
- Avoid prescribing benzos with opioids.
- Make sure patients understand treatment options for constipation.

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NALOXENE/NARCAN

- Naloxene is a pure opioid antagonist.
- May be given IM, IV, SC, IN
- Give 0.4-2mg q 2-3 minutes.
- ACTS in 2-8 minutes
- Lasts for 30-90 minutes but the overdose may return.
- May be repeated.
- CALL EMS!

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Follow-Up Reassessment

- Three questions from the **"PEG SCORE"** have evidence that a 30% improvement from baseline is meaningful.
- 1. What number from 0-10 best describes your pain in the past week? 0=No Pain 10 "Worse Pain"
- 2. What number from 0-10 describes how during the past week pain has interfered with your life?
  0=Not at All 10= "Complete Interference"
- 3. What number from 0-10 describes how, during the past week, pain has interfered with your general activity.
  0=Not at All 10= "Complete Interference"

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INSTRUCTIONS FOR PATIENTS

- Safe guard your medications.
- You can become addicted to pain medications so if you begin to crave drugs because they make you feel good talk to your provider right away. Addiction is a brain disease that may require further treatment.
- No not cut, break, chew, crush, or dissolve your medicines.

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Instructions for Patients

- Avoid Alcohol.
- Avoid Benzodiazepines (like Valium, Xanax, Tranxene).
- Avoid Muscle relaxers (like Soma, Flexeril).
- Avoid Sleeping pills (Like Ambien, Lunesta).
- Never take someone else's medicines.
- Do not drive or operate equipment.
- Take the medications as prescribed.

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To Dispose of Medications

- Mix with Kitty litter or coffee grounds and place in the trash.
- Do not flush medications.
- Some places have a "take back lock box" Check with your pharmacist.

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Helpful Websites

- Prescriberstoprevent.org
- Overdosepreventionalliance.org
- Stopoverdose.org
- Learn2cope.org
- Asam.org
- Store.sanhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742

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Questions?

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Thank you!

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