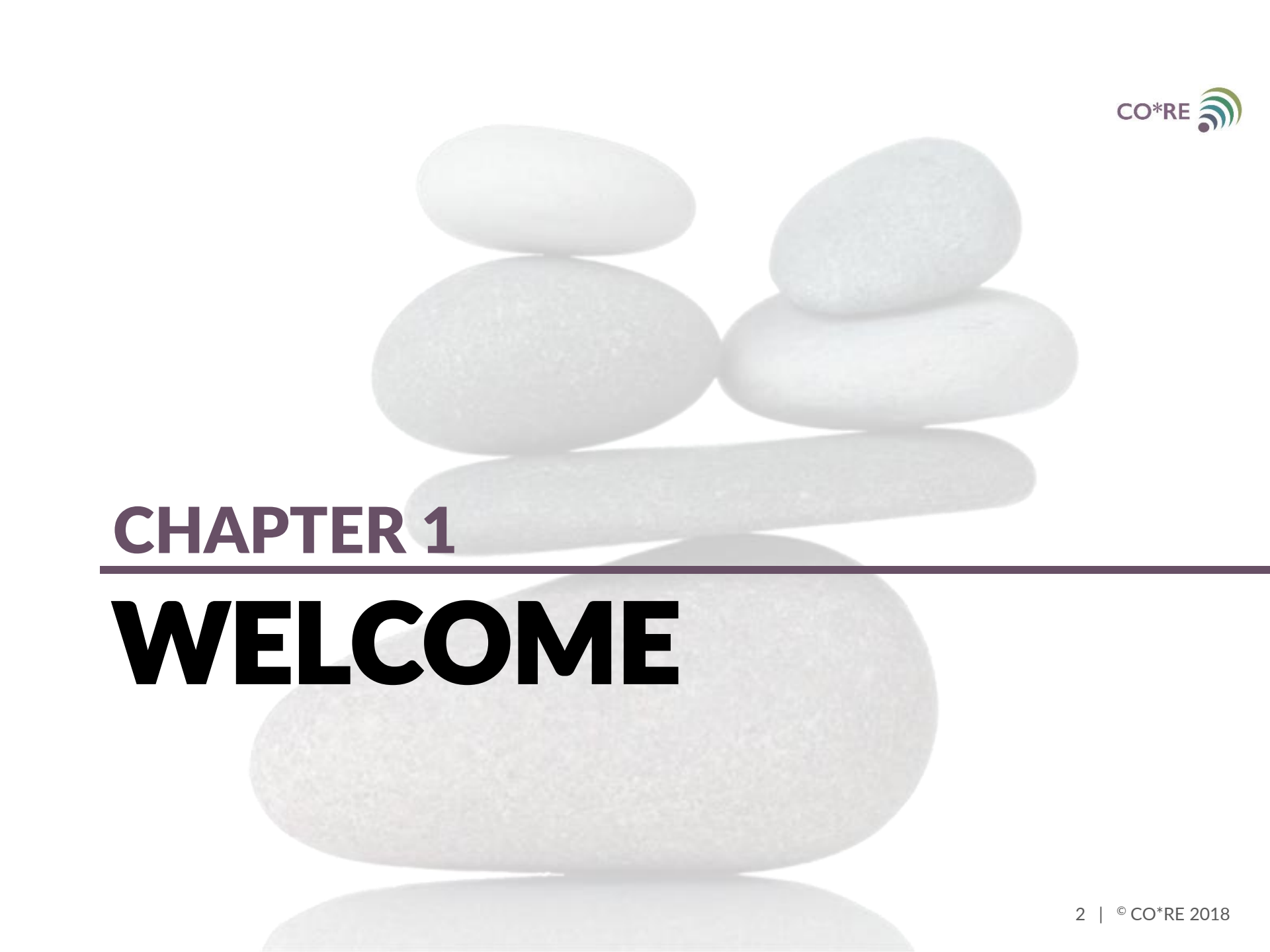
CO*RE COLLABORATION FOR REMS EDUCATION

PRESENTS

Pain Management and Opioids: Balancing Risks and Benefits

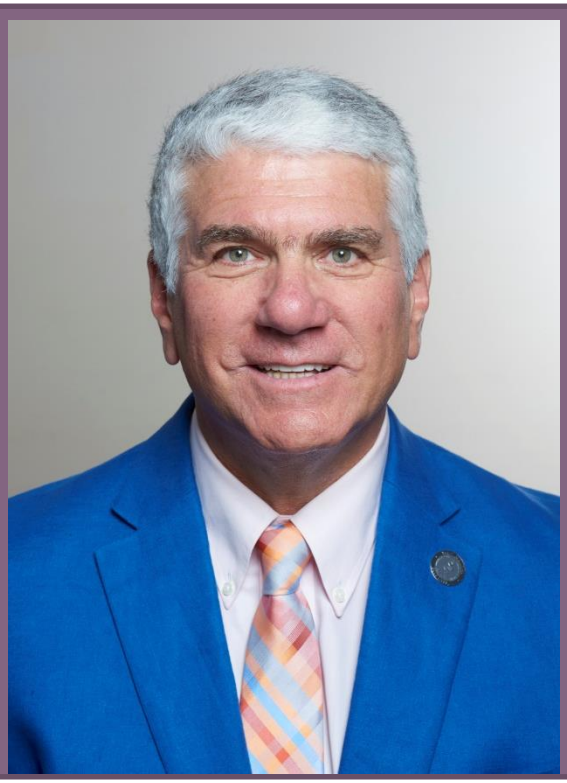
UPDATED IN 2018



CHAPTER 1

WELCOME

Edwin A. Salsitz, MD, DFASAM



Assistant Professor of Medicine
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CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

DISCLOSURE:

Drs. Salsitz and all staff involved with this content declare that neither they nor members of their immediate families have had financial relationships with the manufacturers of goods or services discussed, or corporate supporters of this event.

ORGANIZATIONS

NO CO*RE PARTNER HAS ANY CONFLICTS OF INTEREST TO REPORT (APPENDIX 2)

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ACKNOWLEDGEMENT

Presented by the American Society of Addiction Medicine a member of the Collaborative for Risk Evaluation and Mitigation Strategy (REMS) Education (CO*RE), eleven interdisciplinary organizations working together to improve pain management and prevent adverse outcomes.

This educational activity is supported by an independent educational grant from the Extended-Release/Long-Acting (ER/LA) Opioid Analgesic REMS Program Companies. Please see **this document** for a listing of the member companies. This activity is intended to be fully compliant with the ER/LA Opioid Analgesic REMS education requirements issued by the US Food and Drug Administration.

PRODUCTS COVERED BY THIS REMS

BRAND NAME PRODUCTS

- Arymo ER morphine sulfate ER tablets
- Avinza® morphine sulfate ER capsules
- Belbuca® buprenorphine buccal film
- Butrans® buprenorphine transdermal system
- Dolophine® methadone hydrochloride tablets
- Duragesic® fentanyl transdermal system
- Embeda® morphine sulfate/naltrexone ER capsules
- Exalgo® hydromorphone hydrochloride ER tablets
- Hysingla® ER hydrocodone bitartrate ER tablets
- Kadian® morphine sulfate ER capsules
- MorphaBond® morphine sulfate ER tablets
- MS Contin® morphine sulfate CR tablets
- Nucynta® ER tapentadol ER tablets
- Opana® ER oxymorphone hydrochloride ER tablets
- OxyContin® oxycodone hydrochloride CR tablets
- Targiniq™ ER oxycodone hydrochloride/naloxone hydrochloride ER tablets
- Troxyca ER oxycodone hydrochloride/naltrexone capsules
- Vantrela ER hydrocodone bitartrate ER tablets
- Xtampza ER oxycodone ER capsules
- Zohydro® hydrocodone bitartrate ER capsules

GENERIC PRODUCTS

- 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

CHAPTER 2

WHY ARE WE HERE?

JAMA. 2016;315(17):1826

ALLEVIATING SUFFERING 101 PAIN RELIEF IN THE USA

2011 IOM Report: 116 Million Americans have pain which persists for weeks to years

$560---$635 Billion per year

Some physicians overprescribe opioids, while others refuse to prescribe

Lack of education: Providers and Patients

NEJM 366:3 Jan 19,2012

BREAKTHROUGH PAIN (BTP)

PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP

- Disease progression or a new or unrelated pain
  - Target cause or precipitating factors
- Dose for BTP: using an IR is 5%-15% of total daily opioid dose, administered at an appropriate interval
- Never use ER/LA for BTP

CONSIDER ADDING

- 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
- Non-opioid drug therapies
- Non-pharmacologic treatments

ATC = Around the Clock

TOP 30 OPIOID CONSUMING NATIONS

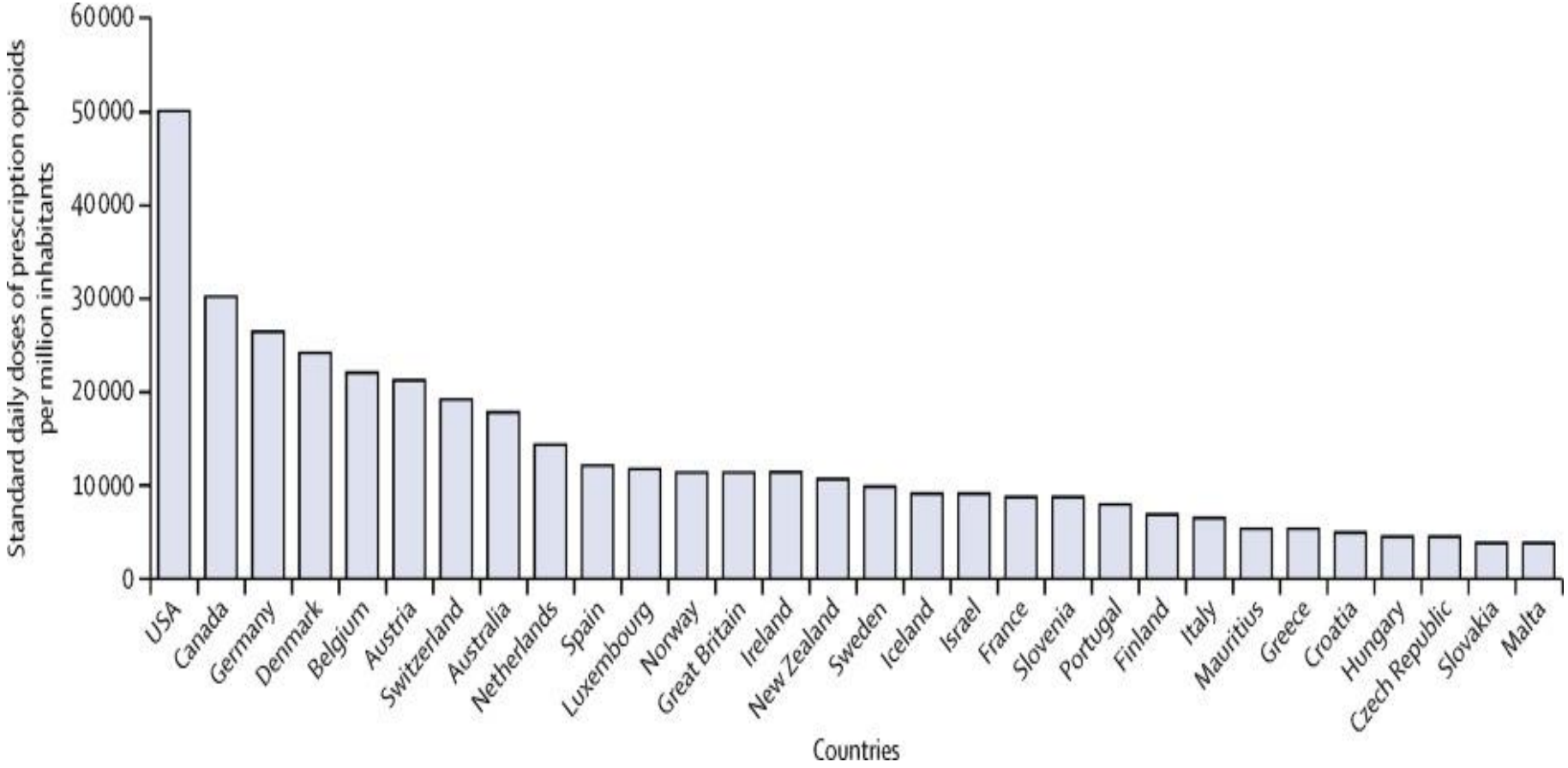


Figure. Top 30 opioid-consuming nations, 2012–147

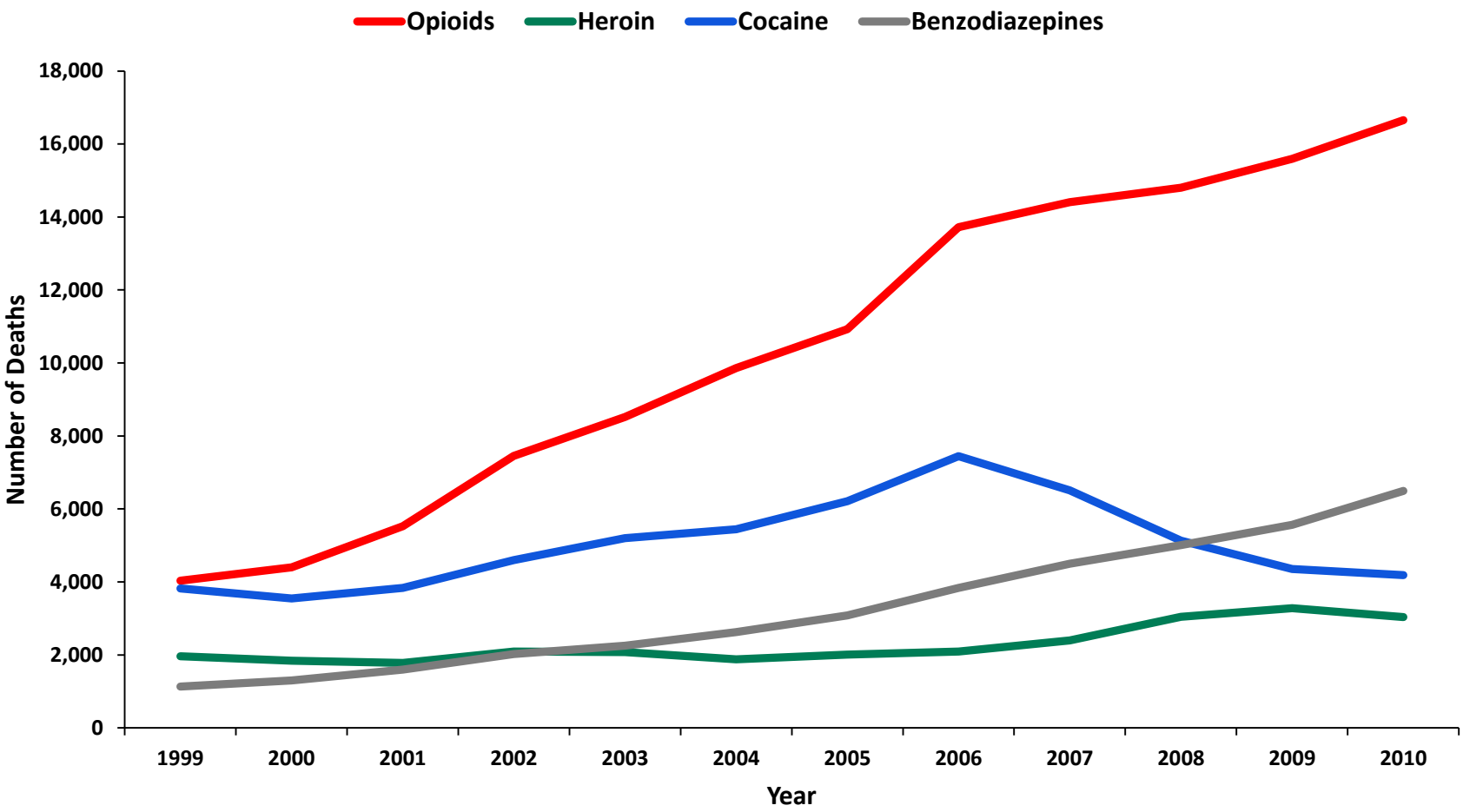
Keith Humphreys

Avoiding globalization of the prescription opioid epidemic

Lancet null, Volume 390, Issue 10093, 2017, 437–439

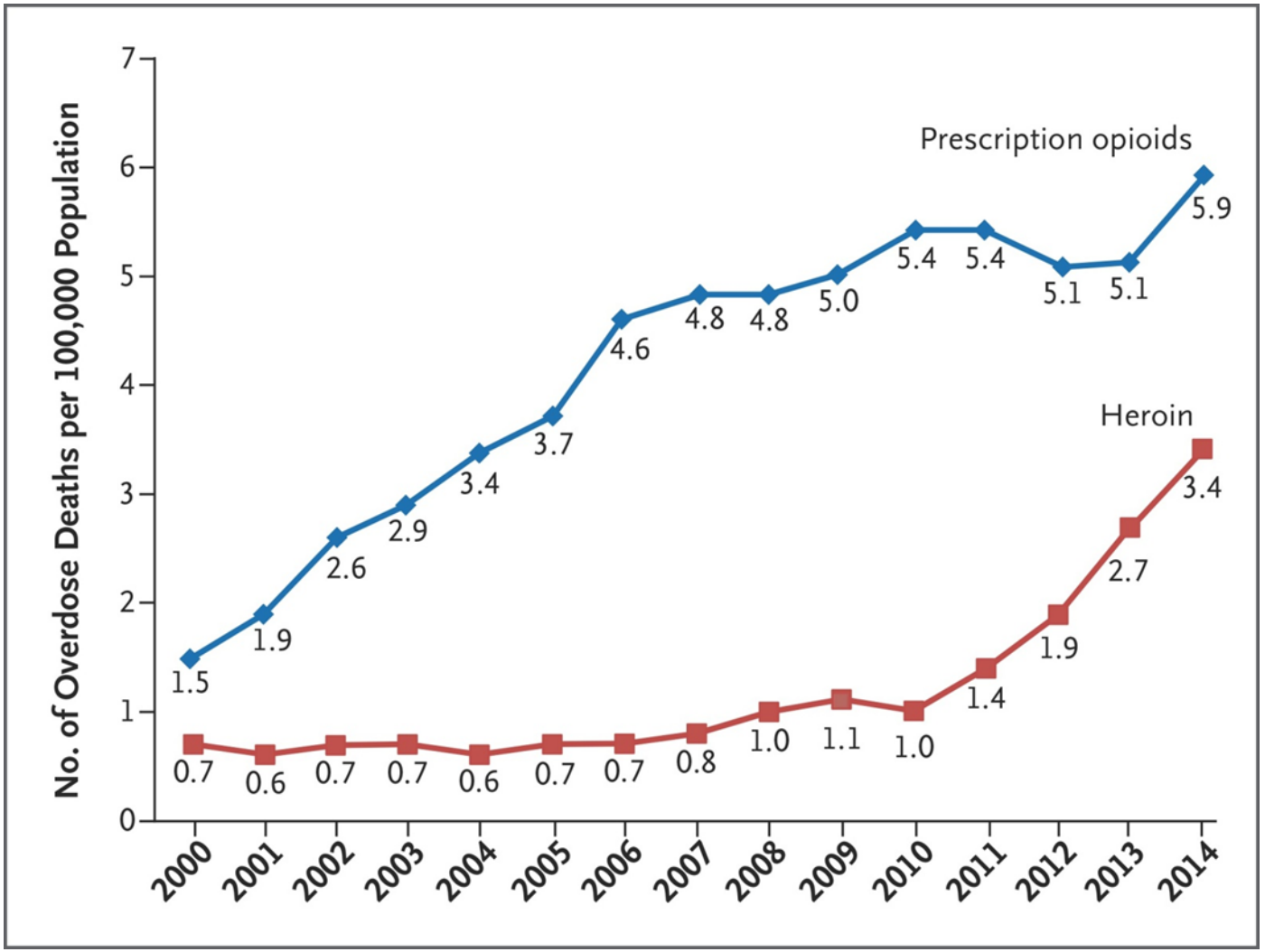
http://dx.doi.org/10.1016/S0140-6736(17)31918-9

DRUG OVERDOSE DEATHS BY MAJOR DRUG TYPE, UNITED STATES, 1999–2010

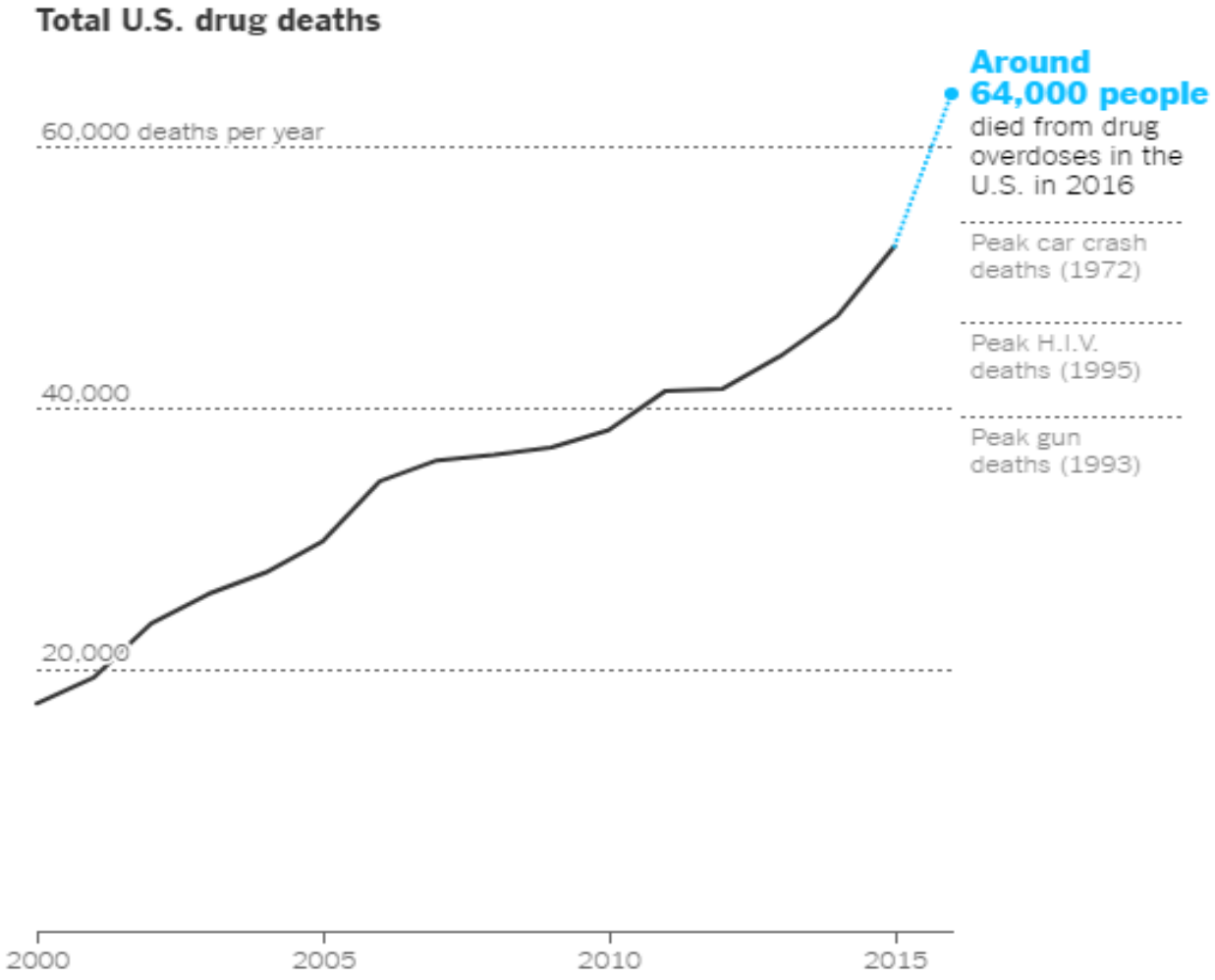


CDC, National Center for Health Statistics, National Vital Statistics System, CDC Wonder. Updated with 2010 mortality data.

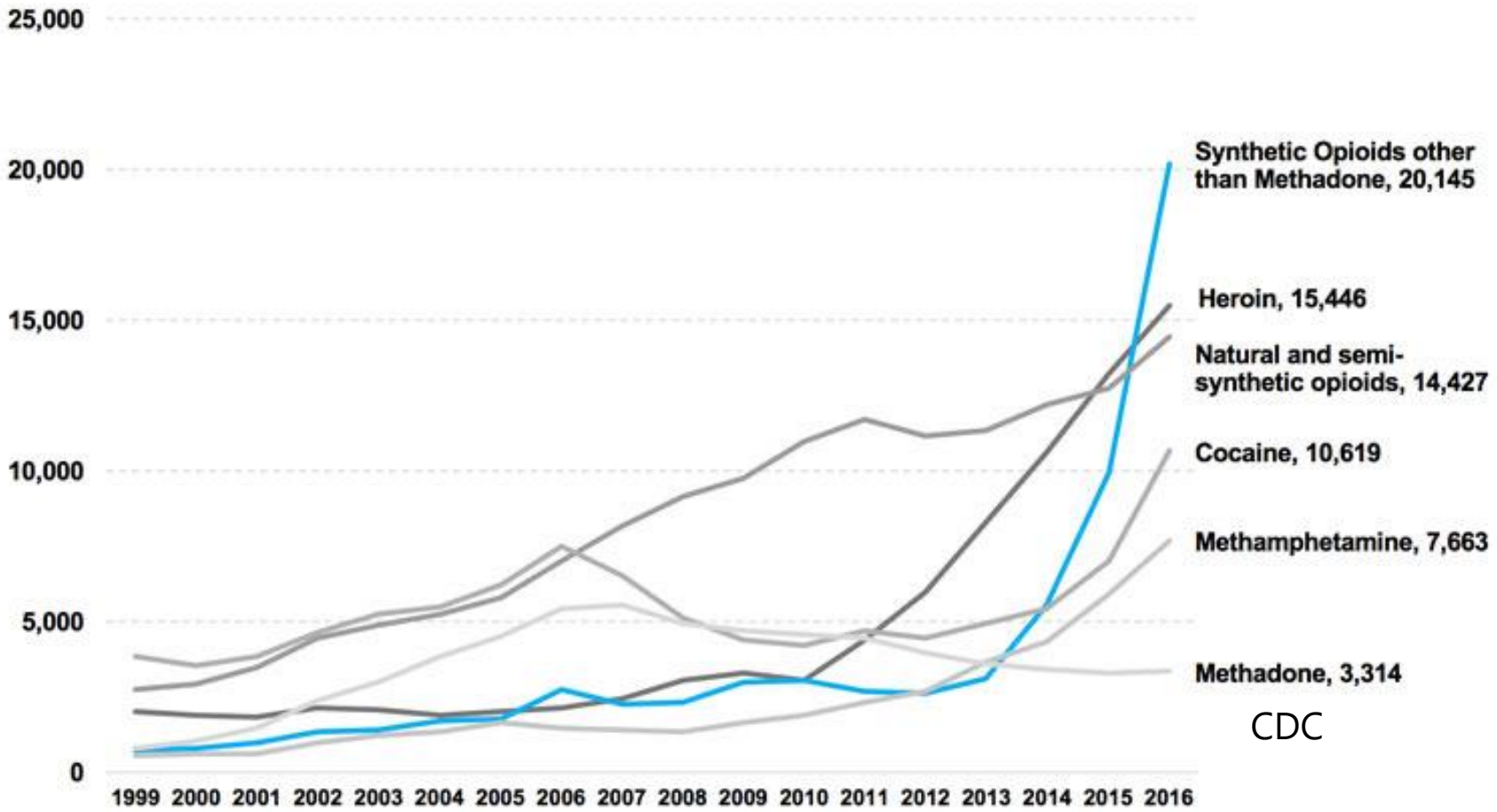
AGE-ADJUSTED RATES OF DEATH RELATED TO PRESCRIPTION OPIOIDS AND HEROIN DRUG POISONING IN THE UNITED STATES, 2000–2014



Compton WM et al. N Engl J Med 2016;374:154-163

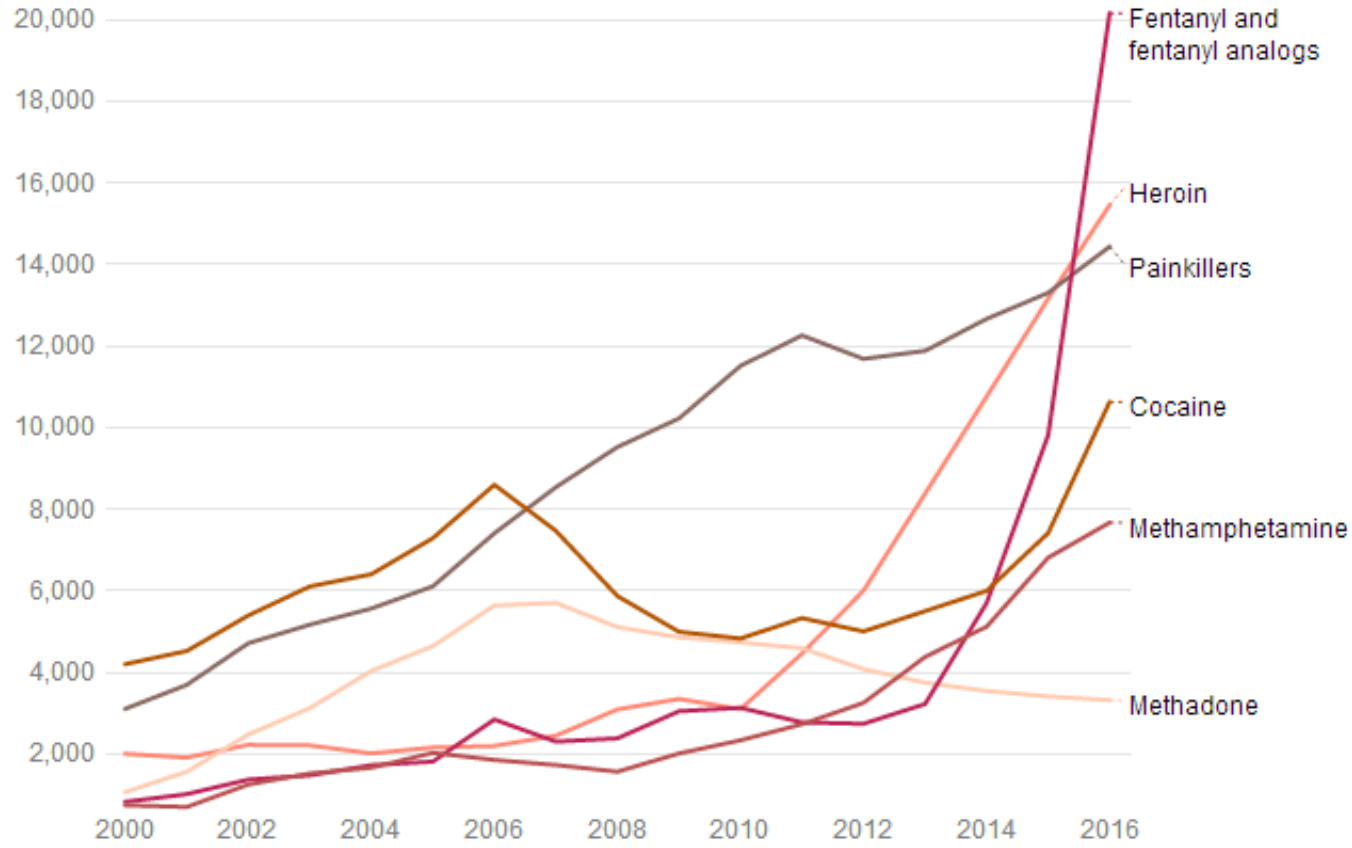

Total U.S. drug deaths
Around 64,000 people died from drug overdoses in the U.S. in 2016
60,000 deaths per year
40,000
20,000
Peak car crash deaths (1972)
Peak H.I.V. deaths (1995)
Peak gun deaths (1993)
2000
2005
2010
2015

Drugs Involved in U.S. Overdose Deaths, 2000 to 2016



CDC

Drugs Involved in Overdose Deaths, 2000-2016



Note: 2016 figures are provisional and cover the 12-month period ending in January 2017.

Source: Centers for Disease Control and Prevention

LETHAL DOSE

Lethal doses of heroin compared to "synthetic" opioids.
New Hampshire State Police Forensic Lab

Synthetic opioids/fentanyl analogues/metabolites	A. All cases (N=100)	B. Acryl Fentanyl Positives (N=56)	C. Furanyl Fentanyl Positives (N=39)
Fentanyl	99 (99%)	56 (100%)	39 (100%)
Norfentanyl	64 (64%)	39 (70%)	26 (67%)
Acryl fentanyl	56 (56%)		25 (64%)
Despropionylfentanyl	46 (46%)	26 (46%)	32 (82%)
Furanyl Fentanyl	39 (39%)	25 (45%)	
Carfentanil	3 (3%)	2 (4%)	1 (2.6%)
Acetyl Fentanyl	2 (2%)	1 (2%)	1 (2.6%)
Butyryl/isobutyrylfentanyl	1 (1%)	0 (0%)	0 (0%)
Furanyl Norfentanyl	1 (1%)	1 (2%)	1 (2.6%)
U47700	1 (1%)	1 (2%)	1 (2.6%)

Boonshoft School of Medicine
WRIGHT STATE UNIVERSITY

Montgomery County Coroner
Miami Valley Crime Laboratory

RESEARCH UPDATE ON FENTANYL OUTBREAKS IN THE DAYTON, OH AREA:

Acryl Fentanyl and Furanyl Fentanyl Commonly Found In Overdose Death Cases

UPDATE 04/28/2017

DAYTON, OHIO. The Dayton area (Montgomery County, Ohio) has recently experienced dramatic increases in heroin and other opioid-related problems. Unintentional drug overdose deaths increased significantly from 127 in 2010 to 264 in 2014. In 2016, there were 349 overdose deaths in Montgomery County, and 251 of them screened positive for fentanyl. Preliminary data from 2017 indicate continuing increases in overdose deaths.

THE STUDY. The research project (R21DA042757) to characterize fentanyl outbreaks in the Dayton, Ohio, area builds on interdisciplinary collaboration between the researchers at the Center for Interventions, Treatment and Additions Research and the Department of Chemistry at Wright State University, and longstanding partnership with the Montgomery County Coroner's Office/Miami Valley Regional Crime Lab (MCCO/MVRC) and Public Health-Dayton & Montgomery County.

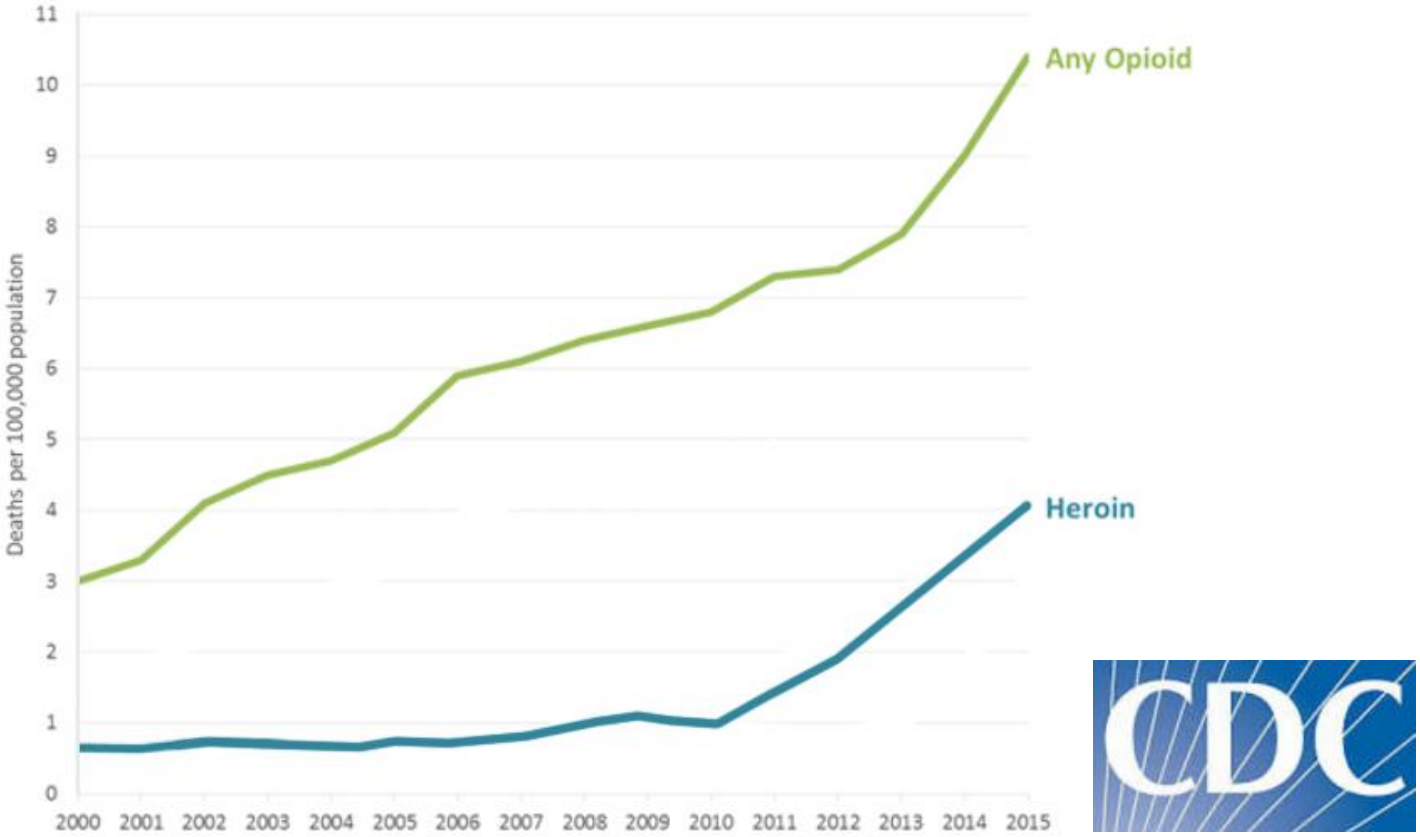
TESTING. The research project developed and validated a qualitative and quantitative liquid-chromatography mass spectrometry (LC-MS/MS) assay for 24 fentanyl analogs/metabolites in biological matrixes (human blood and urine samples):

1-3-Methylfentanyl; 4ANPP; Acetyl Fentanyl; Acetyl Fentanyl 4-Methylphenethyl; Acryl fentanyl; AH7921; Alfentanil; Beta-Hydroxythiofentanyl; Butyryl Fentanyl/Isobutyryl Fentanyl; Butyryl Norfentanyl; Carfentanil; Despropionyl Para-Fluorofentanyl; Fentanyl; Furanyl Fentanyl; Furanyl Norfentanyl; Norfentanyl; Para-Fluorobutyryl/4-Fluoroisobutyrylfentanyl; Para-Methoxyfentanyl; Remifentanil; Remifentanil Metabolite; Sufentanil; U-47700; Valeryl Fentanyl

2 Minutes: 3A4

100 Accidental OD deaths 2017(3mos): 99% + FENTANYL Only 3 cases + HEROIN

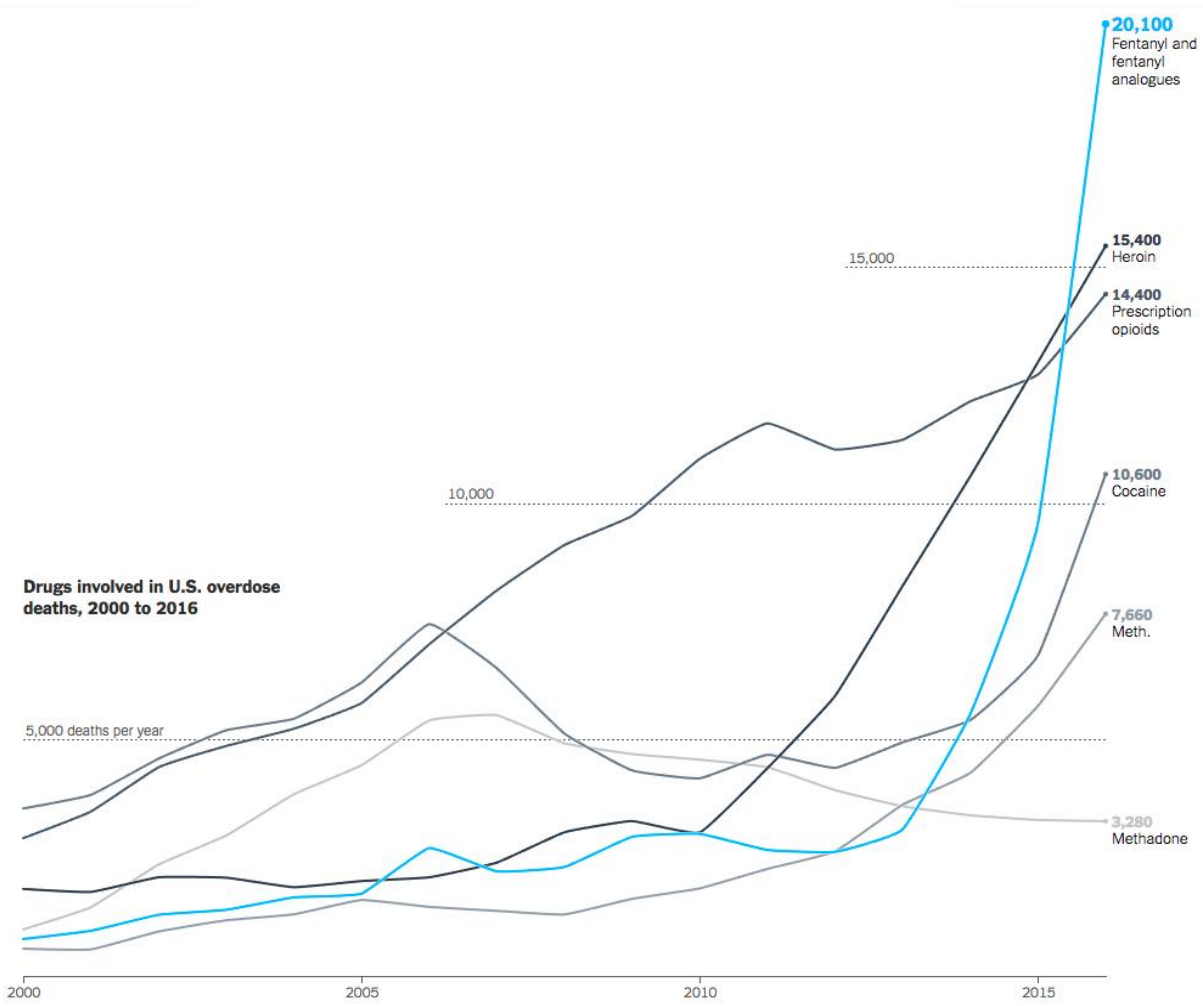
OVERDOSE DEATHS INVOLVING OPIOIDS, U.S, 2000-2015



SOURCE: MMWR, January 1, 2016/64(50);1378-82
https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm

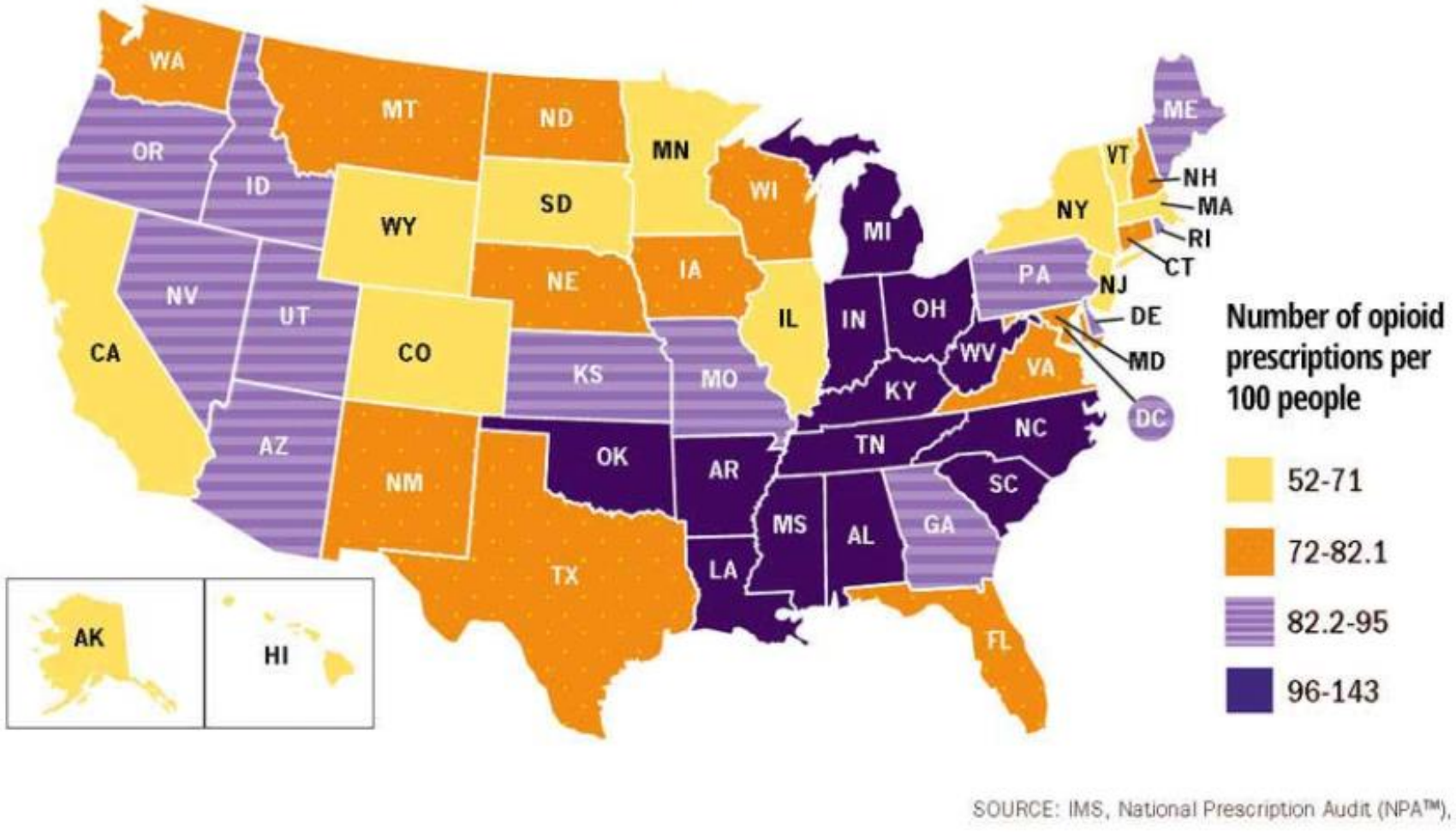
DRUGS INVOLVED IN U.S. OVERDOSE DEATHS 2000-2016

20,100 deaths fentanyl & fentanyl analogues



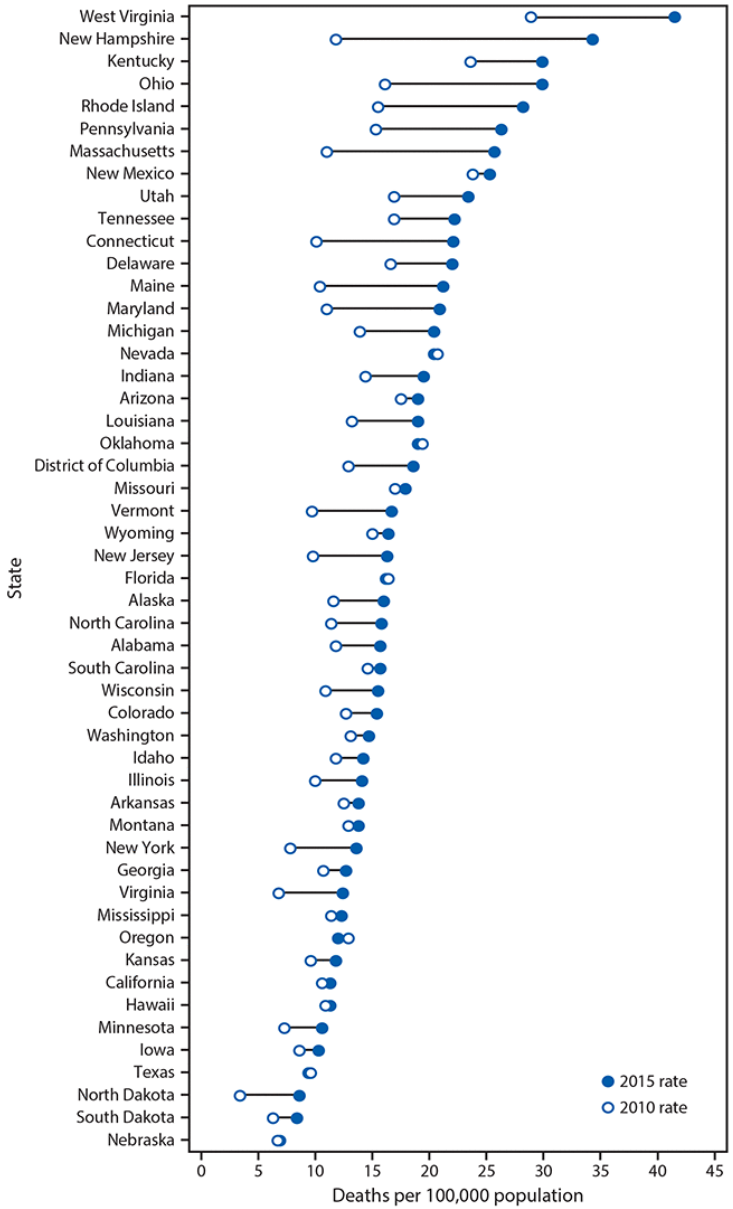
SOURCE: https://www.nytimes.com/interactive/2017/09/02/upshot/fentanyl-drug-overdose-deaths.html?_r=0

PRESCRIBING PATTERNS – WE PLAY A ROLE

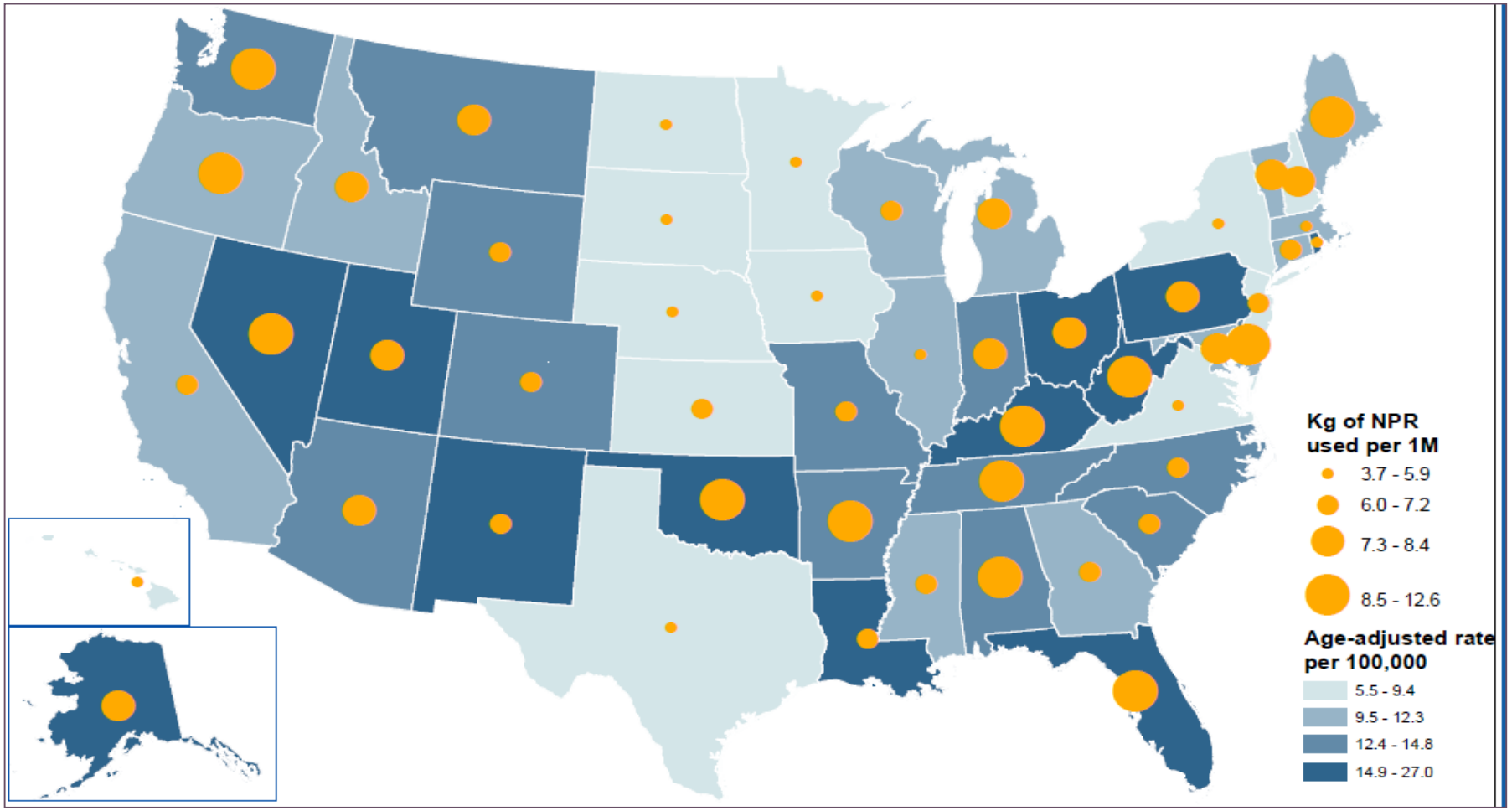


SOURCE: https://www.cdc.gov/drugoverdose/data/prescribing.html

AGE-ADJUSTED RATE* OF DRUG OVERDOSE DEATHS, BY STATE — 2010 AND 2015 CDC



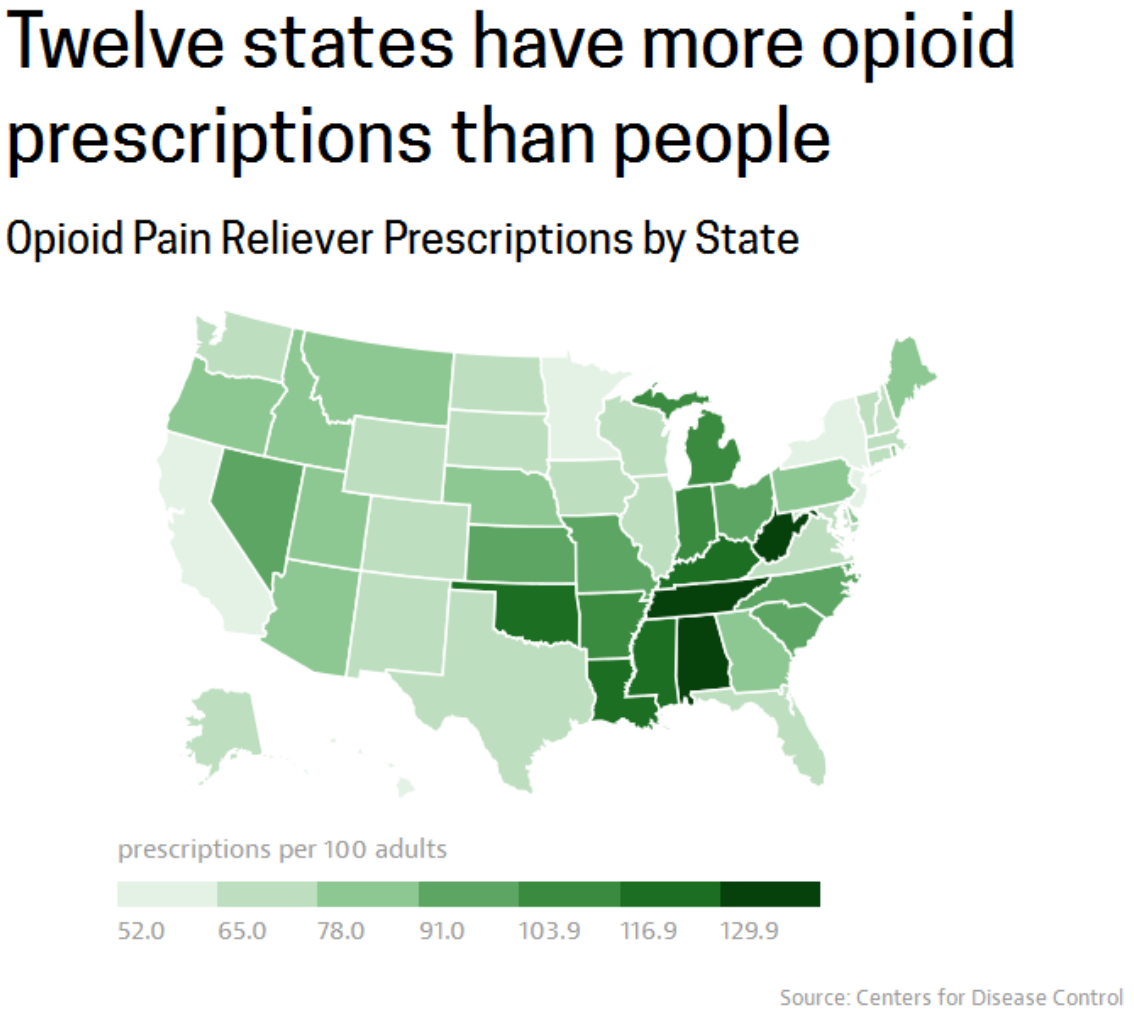
DRUG OVERDOSE DEATH RATE, 2008, AND OPIOID PAIN RELIEVER SALES RATE, 2010



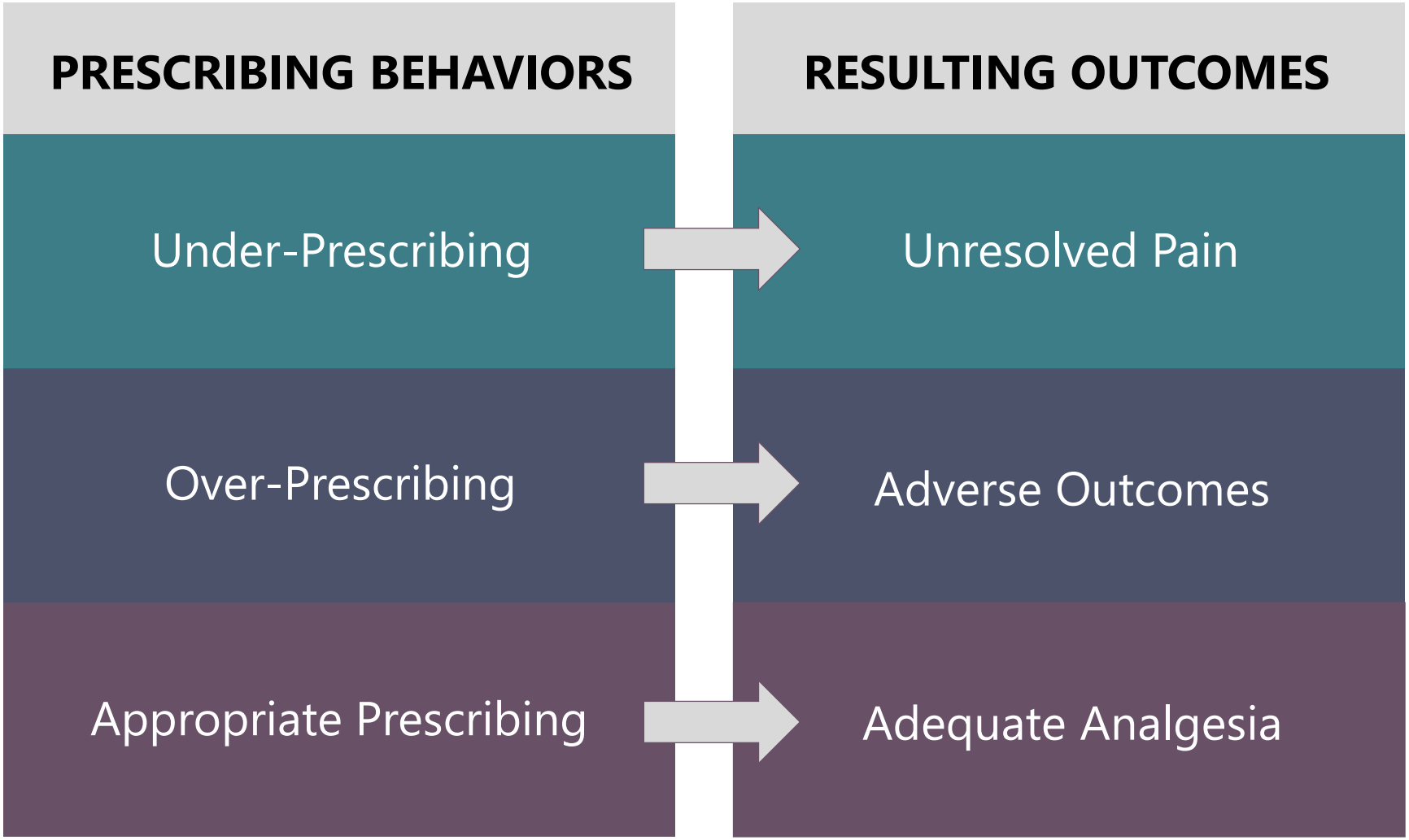
National Vital Statistics System, 2008; Automated Reports Consolidated Orders System, 2010.

Alabama: 142.9*
Tennessee: 142.8
West Virginia: 137.6
Kentucky: 128.4
Oklahoma: 127.8
Mississippi: 120.3
Louisiana: 118
Arkansas: 115.8
Indiana: 109.1
Michigan: 107
South Carolina: 101.8
Ohio: 100.1

**per 100 people*



OPIOID PRESCRIBING - THE PENDULUM SWINGS



BENEFITS VS. RISKS

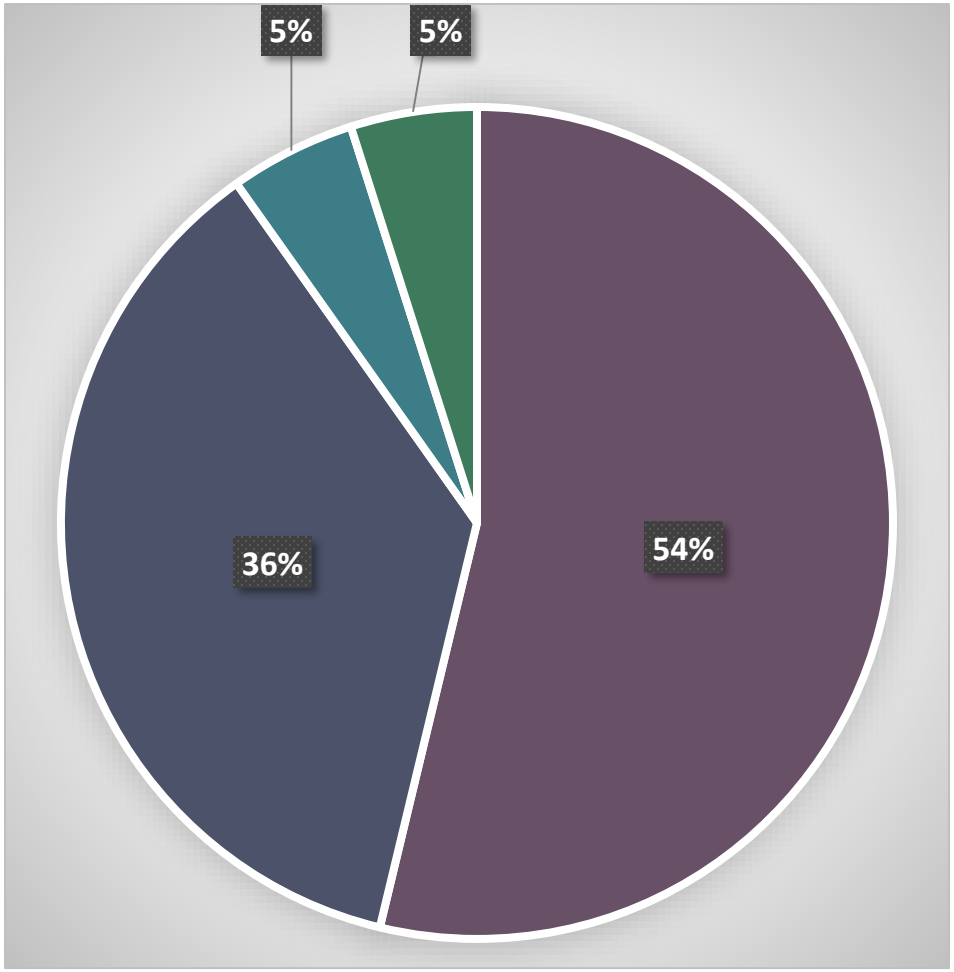
BENEFITS

- Analgesia
  - Adequate pain control
  - Continuous, predictable (with ER/LAs)
- Improved function
- Quality of life

RISKS

- Overdose, especially as ER/LA formulations contain more opioids than Immediate Release
- Life-threatening respiratory depression
- Abuse by patient or household contacts
- Misuse, diversion, and addiction
- Physical dependence and tolerance
- Interactions with other meds and substances
- Risk of neonatal opioid withdrawal syndrome

SOURCE OF MOST RECENT RX OPIOIDS AMONG PAST-YEAR MISUSERS 2015



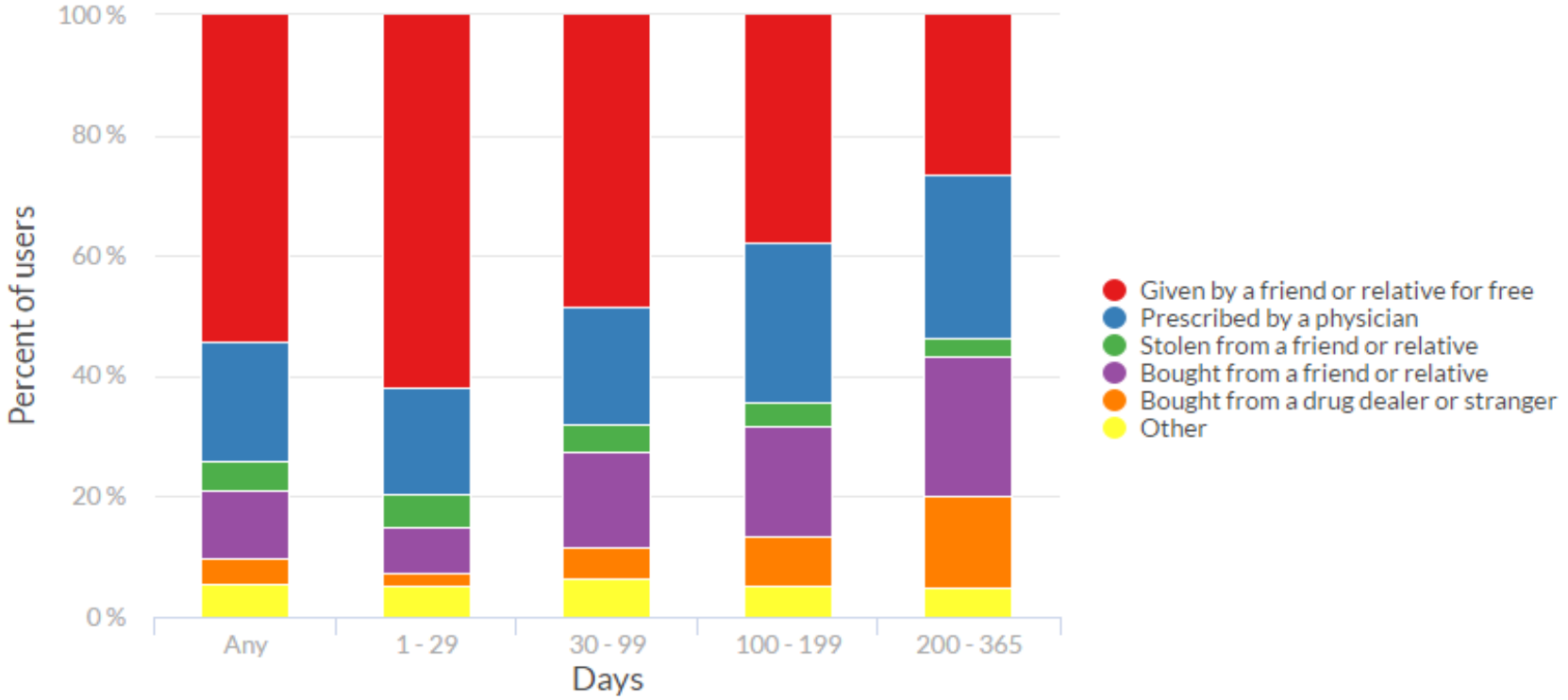
Source where pain relievers were obtained for most recent misuse among 12.5 million people aged 12 or older who misused prescription pain relievers in the past year: percentages, 2015

- **54% - Given by, bought from, or taken from a friend or relative**
- **36% - Through a prescription or stolen from healthcare provider**
- **5% - Bought from a dealer or stranger**
- **5% - Some other way**

SOURCE: Prescription Drug Use and Misuse in the United States:
Results from the 2015 National Survey on Drug Use and Health, Sept 2016
https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm

Sources of prescription opioid pain relievers

*Other includes written fake prescriptions or other methods of stealing or purchased on the internet.



Sources: U.S. National Survey on Drug Use and Health 2008-2011, JAMA

TRENDCT.ORG

From: **Prescription Opioid Analgesics Commonly Unused After Surgery: A Systematic Review**

JAMA Surg. Published online August 02, 2017. doi:10.1001/jamasurg.2017.0831

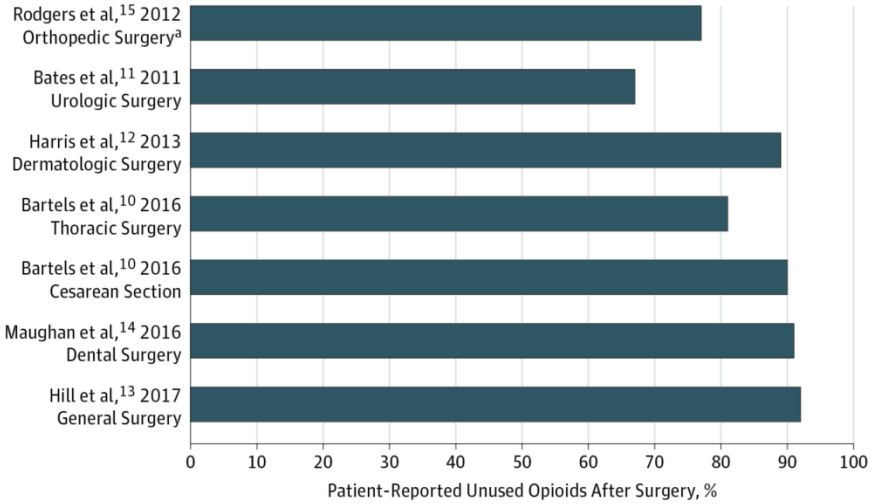
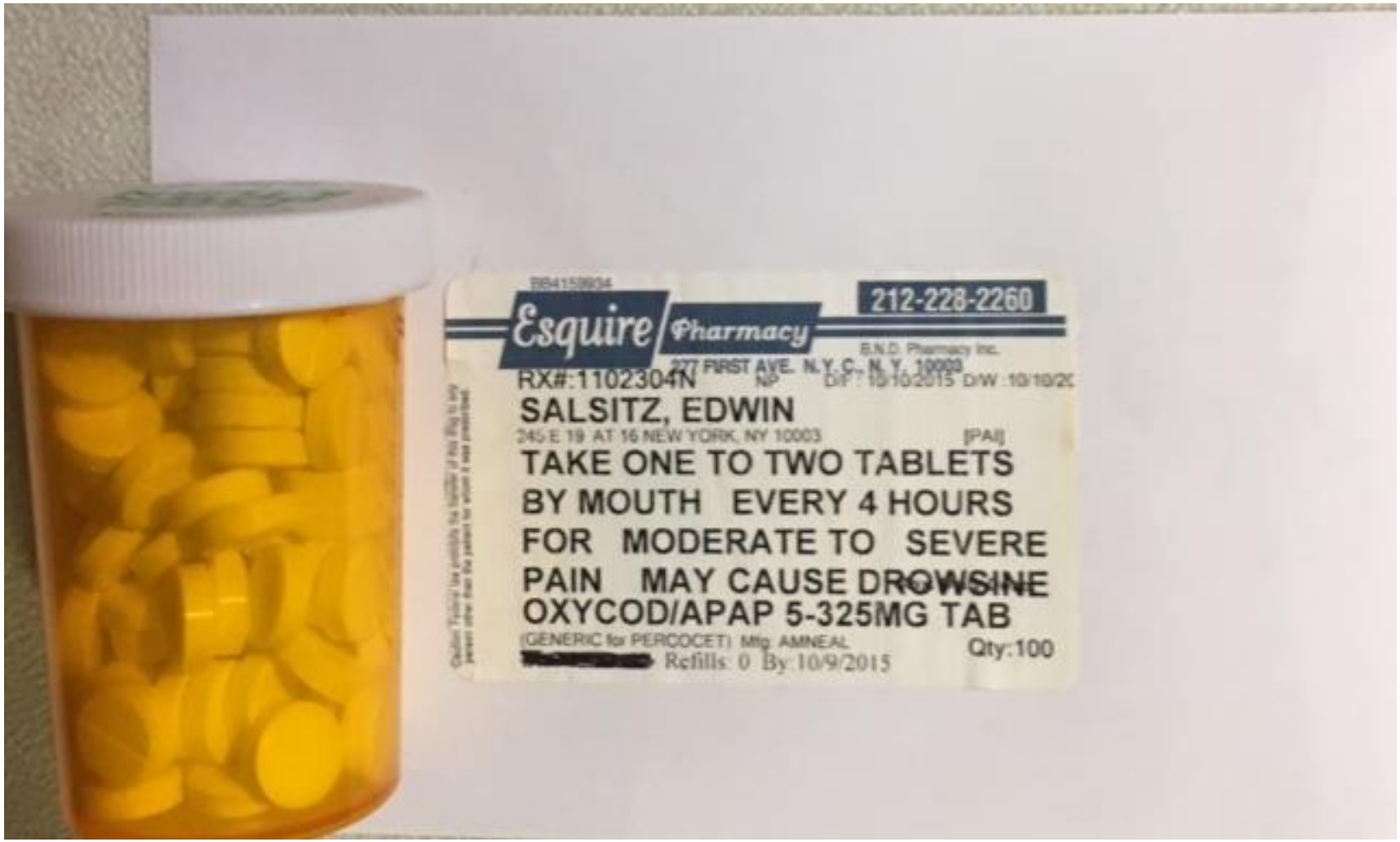


Figure Legend:

Prevalence of Unused Opioids Prescribed After Surgery Percentage of patients reporting use of 15 tablets or fewer.

TOOK 1 OXYCODONE 10MG DAY 2



THE FEDERAL PLAYERS

Many agencies involved

SURGEON GENERAL .GOV

CDC

Office of National Drug Control Policy

NIH National Institute on Drug Abuse
The Science of Drug Abuse & Addiction

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

WE ARE HERE
BECAUSE OF …

FDA

REMS: RISK EVALUATION AND MITIGATION STRATEGY

- 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
- First time FDA has ever used accredited CE/CME as part of a REMS

CO*RE STATEMENT

Misuse, abuse, diversion, addiction, and overdose of opioids has created a serious public health epidemic in the U.S.

When prescribed well and used as prescribed, opioids can be valuable tools to effectively treat pain.

This course does not advocate for or against the use of Immediate Release (IR) or Extended-Release/Long-Acting (ER/LA) opioids. Our purpose is to provide proper education about safe prescribing practices along with effective patient education.

LEARNING OBJECTIVES

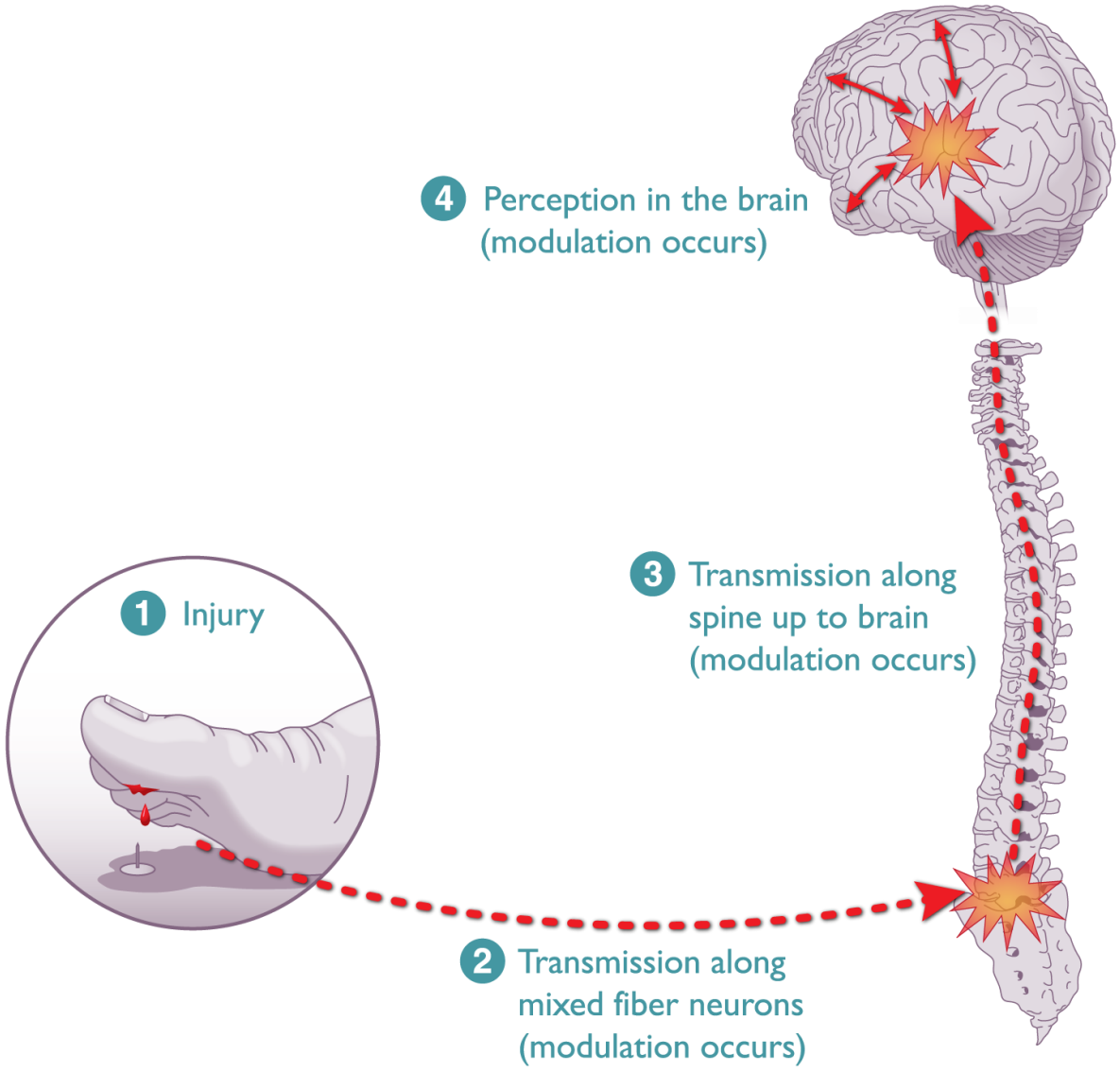
- Accurately assess patients with pain for consideration of an opioid trial
- Establish realistic goals for pain management and restoration of function
- Initiate opioid treatment (IR and ER/LA) safely and judiciously, maximizing efficacy while minimizing risks
- Monitor and re-evaluate treatment continuously; discontinue safely when appropriate
- Counsel patients and caregivers about use, misuse, abuse, diversion, and overdose
- Educate patients about safe storage and disposal of opioids
- Demonstrate working knowledge and ability to access general and specific information about opioids, especially those used in your practice

You and Your Team *can* have an immediate and positive impact on this crisis while also caring for your patients appropriately.

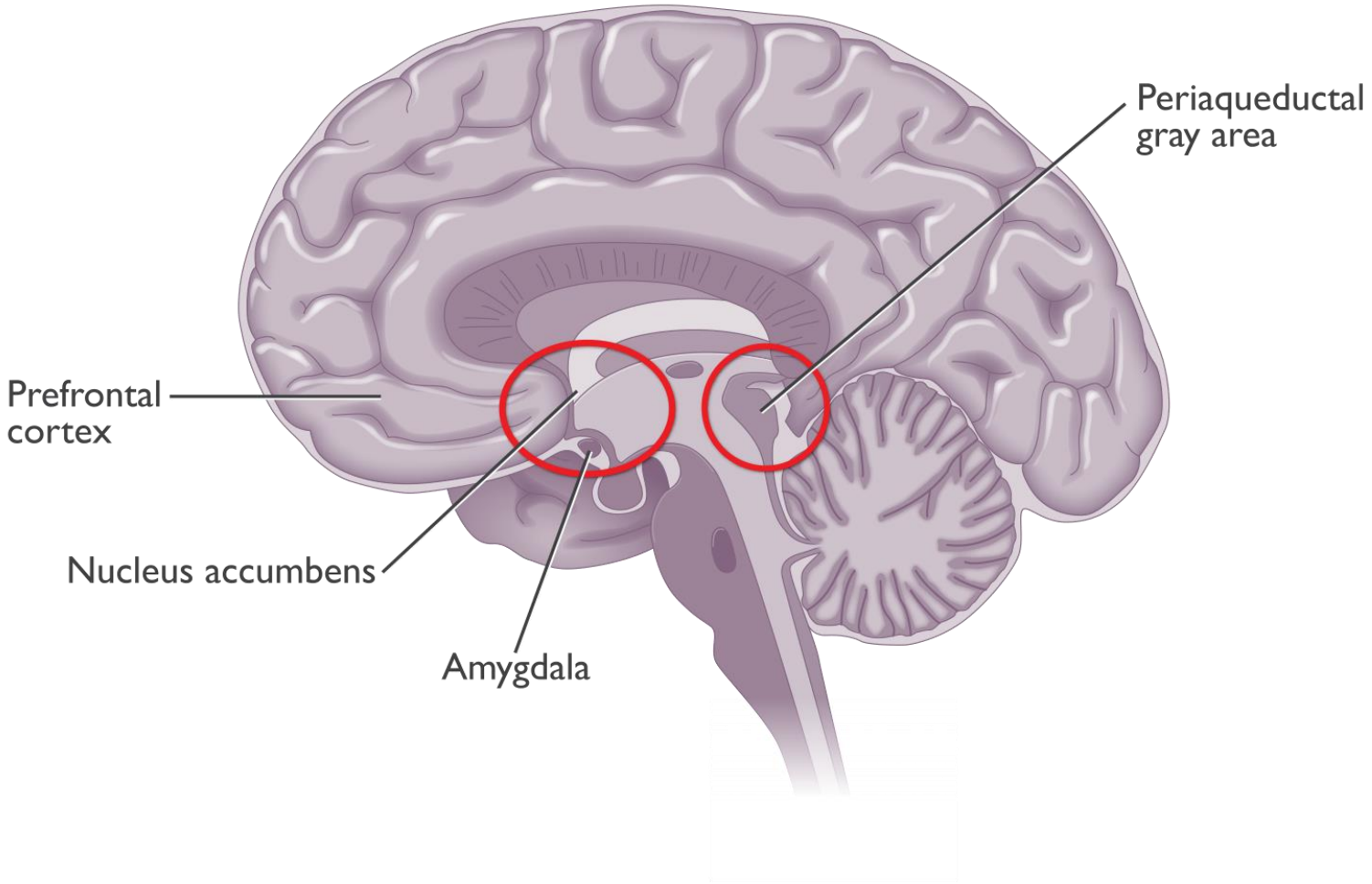
CHAPTER 3

PAIN

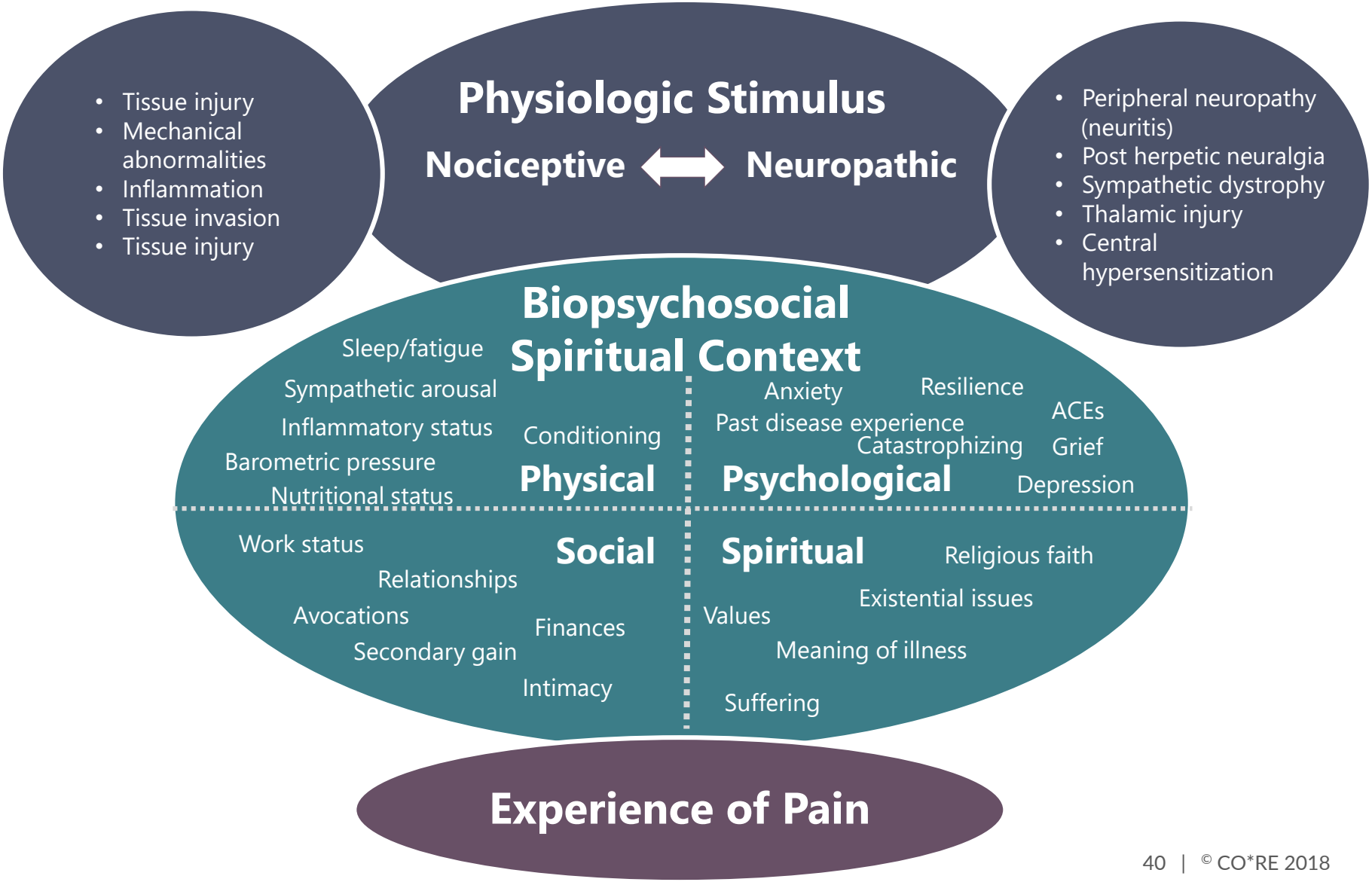
THE NEUROPSYCHOBIOLOGY OF PAIN



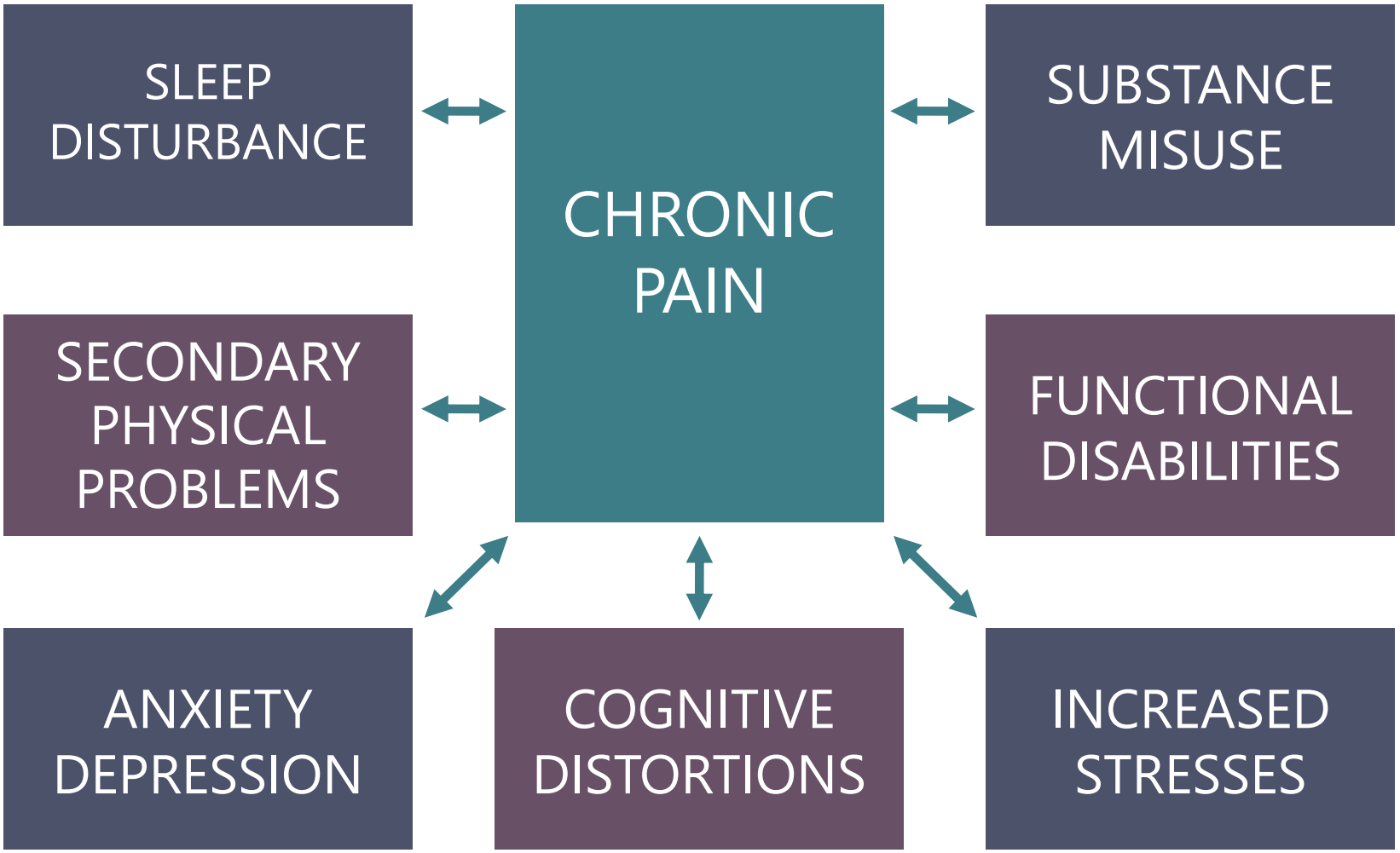
OPIOID SITES OF ACTION IN THE BRAIN



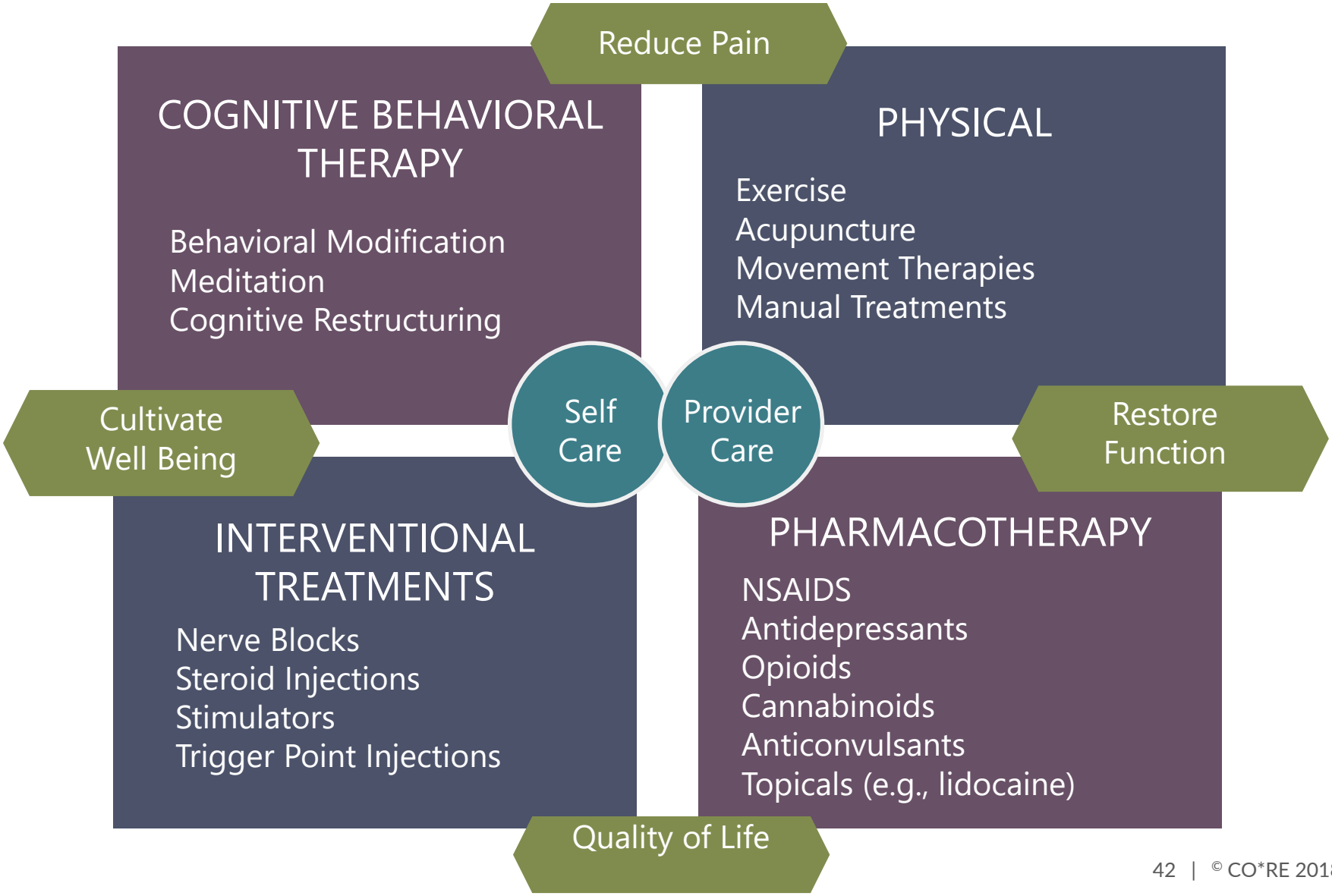
UNDERSTANDING PAIN



THE IMPACT OF PAIN

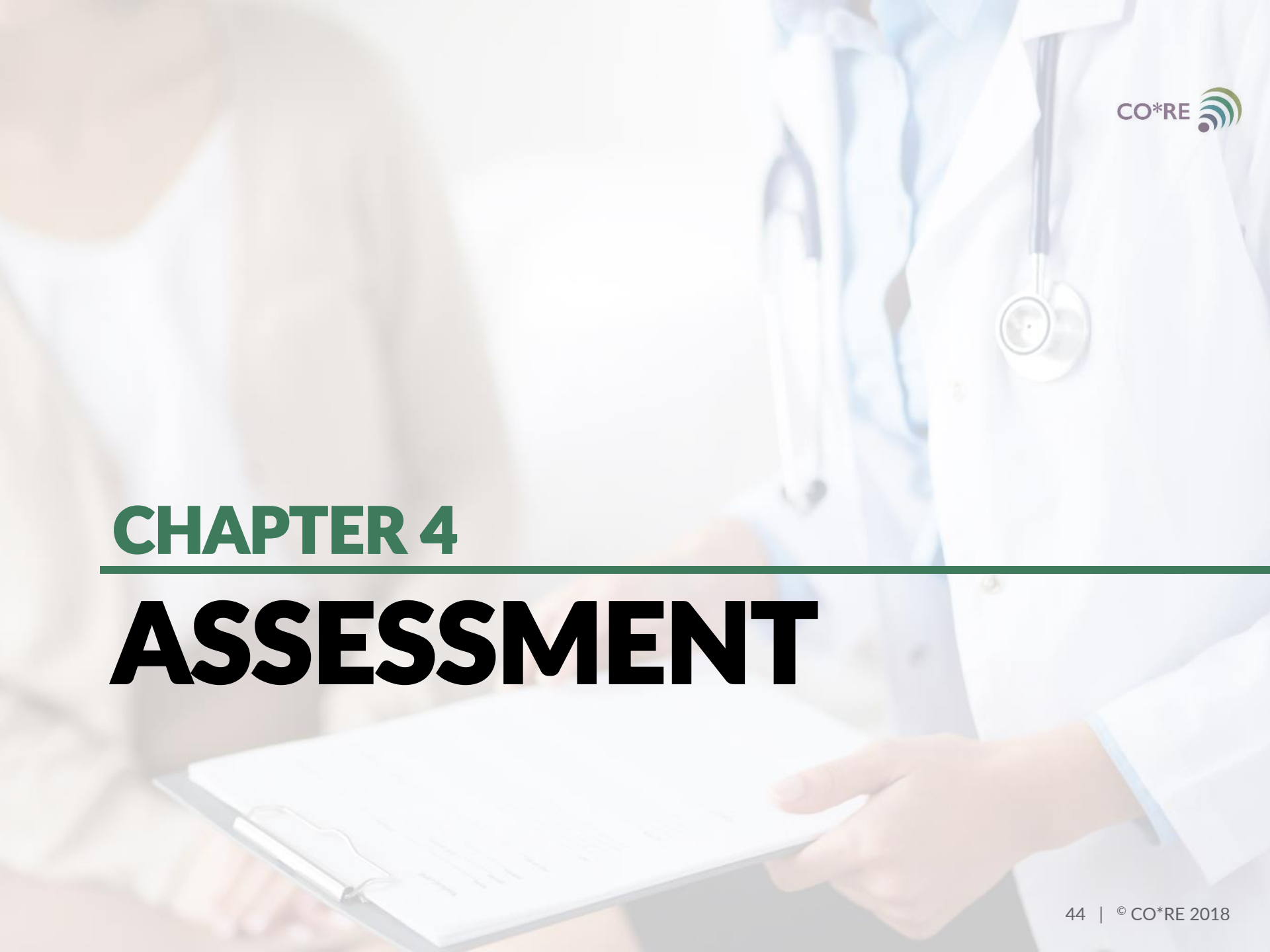


PAIN MANAGEMENT GOALS AND TREATMENT OPTIONS: A MULTI-MODAL APPROACH



CHAPTER 3 - PEARLS FOR PRACTICE

- Explain neurophysiology of pain processing to patients
- When patients understand, their concerns are validated
- Pain has biological, psychological, social, and spiritual components



CHAPTER 4

ASSESSMENT

PAIN ASSESSMENT

DESCRIPTION OF PAIN

Location

Intensity

Quality

Onset/
Duration

Variations/
Patterns/Rhythms

WHAT RELIEVES THE PAIN?

WHAT CAUSES OR INCREASES PAIN?

EFFECTS OF PAIN ON PHYSICAL, EMOTIONAL, AND PSYCHOSOCIAL FUNCTION

PATIENT'S CURRENT PAIN AND FUNCTION

SOURCE: 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.

TREATMENT HISTORY

NON-PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PAST USE

CURRENT USE

- Query state Prescription Drug Monitoring Program (**PDMP)** to confirm patient report
- Contact past providers and obtain prior medical records

DOSAGE

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

GENERAL EFFECTIVENESS

PAST 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 USE DISORDER (SUD):

- Hepatitis
- HIV
- Tuberculosis
- Cellulitis
- STIs
- Trauma/Burns
- Cardiac Disease
- Pulmonary Disease

SOURCE: 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.

OBTAIN A COMPLETE HISTORY OF CURRENT AND PAST SUBSTANCE USE

RISK FACTORS FOR OPIOID ABUSE

- Controlled medications: prescribed or non-prescribed
- Alcohol and tobacco
- History of sexual abuse
- Family history of substance abuse and psychiatric disorders
- Age (16-45 YO)

Substance abuse history does not prohibit treatment with ER/LA opioids but may require additional monitoring and expert consultation/referral

SOCIAL HISTORY

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

PHYSICAL EXAM AND ASSESSMENT

Seek objective confirmatory data

Components of patient evaluation for pain

Order diagnostic tests (appropriate to complaint)

General: vital signs, appearance, and pain behaviors

Neurologic exam

Musculoskeletal exam
- Inspection
- Gait and posture
- Range of motion
- Palpation
- Percussion
- Auscultation
- Provocative maneuvers

Cutaneous or trophic findings

SOURCE: 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.

RISK ASSESSMENT TOOLS

TOOL	# OF ITEMS	ADMINISTERED BY
PATIENTS CONSIDERED FOR LONG-TERM OPIOID THERAPY		
ORT Opioid Risk Tool	5	patient
SOAPP® Screener and Opioid Assessment for Patients with Pain	24, 14, & 5	patient
DIRE Diagnosis, Intractability, Risk, and Efficacy score	7	clinician
CHARACTERIZE MISUSE ONCE OPIOID TREATMENT 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, Adapted to Include Drugs	4	clinician
RAFFT Relax, Alone, Friends, Family, Trouble	5	patient
DAST Drug Abuse Screening Test	28	patient
SBIRT Screening, Brief Intervention, and Referral to Treatment	Varies	clinician

OPIOID RISK TOOL (ORT)

Mark each box that applies	Female	Male
1 Family history 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 and 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

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

SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN (SOAPP)®

Identifies patients as 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 with a nurse, physician, or psychologist

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

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

CONSIDER A TRIAL OF AN OPIOID?

POTENTIAL BENEFITS ARE LIKELY TO OUTWEIGH RISKS

FAILED TO ADEQUATELY RESPOND TO NON-OPIOID & NONDRUG INTERVENTIONS

PAIN IS MODERATE TO SEVERE

INITIATE TRIAL OF IR OPIOIDS

SOURCE: 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.

INITIATING OPIOIDS: CDC GUIDELINE (2016)

- Begin with IR
- Prescribe the lowest effective dosage
- Use caution at any dosage, but particularly when
  - Increasing dosage to ≥50 morphine milligram equivalents (MME)/day and carefully justify a decision to titrate dosage to ≥90 MME/day
- For acute pain, prescribe lowest effective dose of IRs, no more than needed
- Re-evaluate risks/benefits within 1 - 4 weeks of initiation or dose escalation
- Re-evaluate risks/benefits every 3 months; if benefits do not outweigh harms optimize other therapies, work to taper and discontinue
- Link to the Guideline: https://www.cdc.gov/drugoverdose/prescribing/providers.html

Cancer pain, hospice, and palliative care patients are not covered by CDC Guideline

INFORMED CONSENT

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

- ANALGESIC AND FUNCTIONAL GOALS OF TREATMENT
- EXPECTATIONS
- POTENTIAL RISKS
- ALTERNATIVES TO OPIOIDS

HOW TO MANAGE

- Common Adverse Effects (AEs) (e.g., constipation, nausea, sedation)
- Risks (e.g., abuse, addiction, respiratory depression, overdose)
- AEs with long-term therapy (e.g., hyperalgesia, low testosterone, irregular menses or sexual dysfunction)

PATIENT-PRESCRIBER AGREEMENT (PPA)

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

- CLARIFY TREATMENT PLAN AND GOALS OF TREATMENT WITH PATIENT, PATIENT'S FAMILY, AND OTHER CLINICIANS INVOLVED IN PATIENT'S CARE
- ASSIST IN PATIENT EDUCATION
- DISCUSS MEDICATION SAFE HANDLING, STORAGE, AND DISPOSAL
- DOCUMENT PATIENT AND PRESCRIBER RESPONSIBILITIES

PATIENT PROVIDER AGREEMENT (PPA)

REINFORCE EXPECTATIONS FOR APPROPRIATE AND SAFE OPIOID USE

- One prescriber
- Consider one pharmacy
- Safeguard
  - Do not store in medicine cabinet
  - Keep locked (medication safe)
  - Do not share or sell
- Instructions for disposal when no longer needed
- Prescriber notification for any event resulting in a pain medication prescription
- Follow-up
- Monitoring
  - Random UDT and pill counts
- Refills
- Identify behaviors for discontinuation
- Exit strategy

MONITOR ADHERENCE AND ABERRANT BEHAVIOR

ROUTINELY MONITOR PATIENT ADHERENCE TO TREATMENT PLAN

- Recognize and document aberrant drug-related behavior
  - In addition to patient self-report also use:
    - State PDMPs
    - UDT
      - Positive for non-prescribed 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 and Documentation Tool

ADDRESS ABERRANT DRUG-RELATED BEHAVIOR

Behavior outside the boundaries of agreed-on treatment plan:

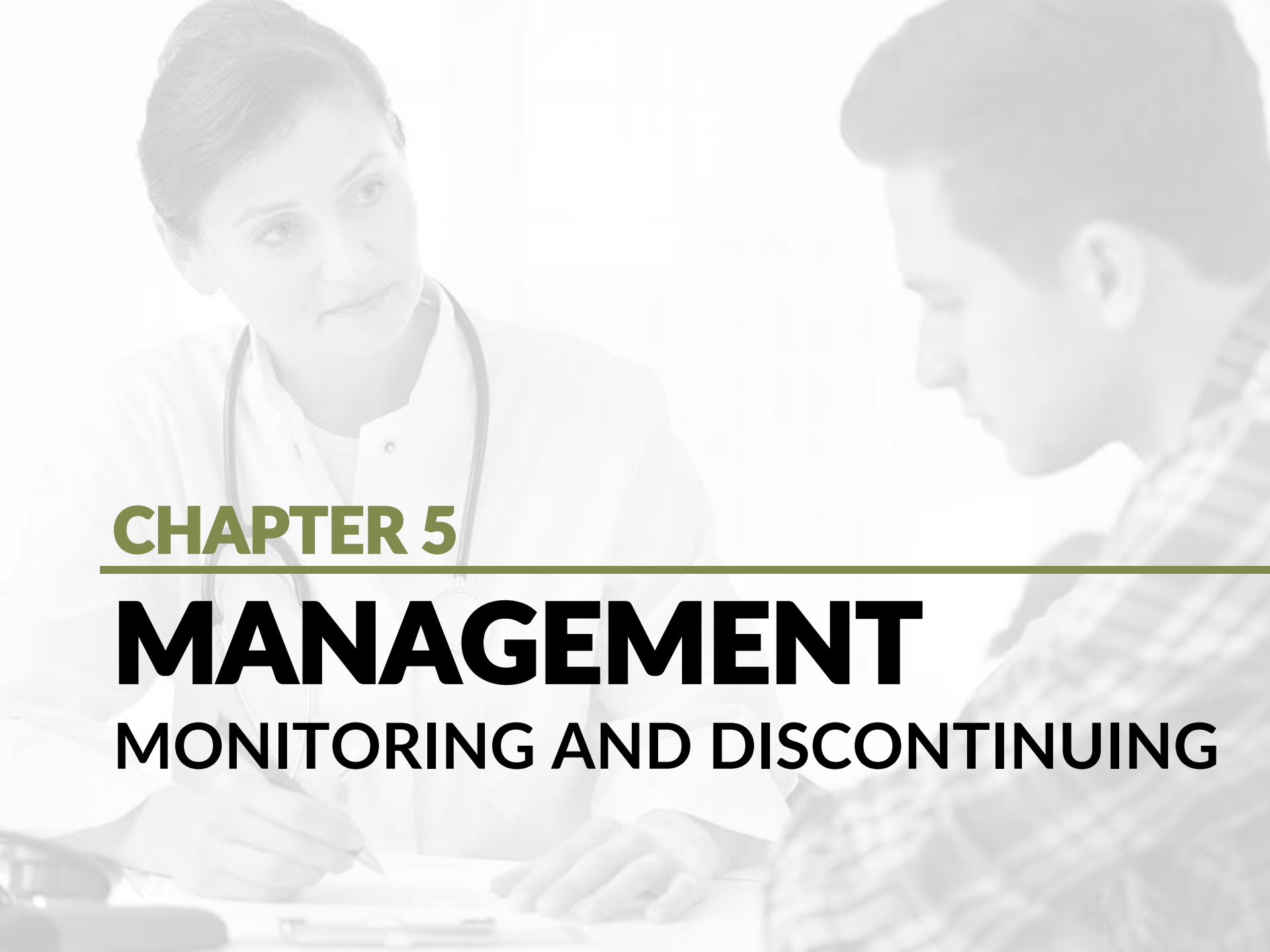
- Unsanctioned dose escalations or other noncompliance with therapy on 1 or 2 occasions
- Unapproved use of the drug to treat another symptom
- Openly acquiring similar drugs from other medical sources
- Multiple dose escalations or other noncompliance with therapy despite warnings
- Prescription forgery
- Obtaining prescription drugs from nonmedical sources

Any of these behaviors merit **investigation**, proceed with caution

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

CHAPTER 4 – PEARLS FOR PRACTICE

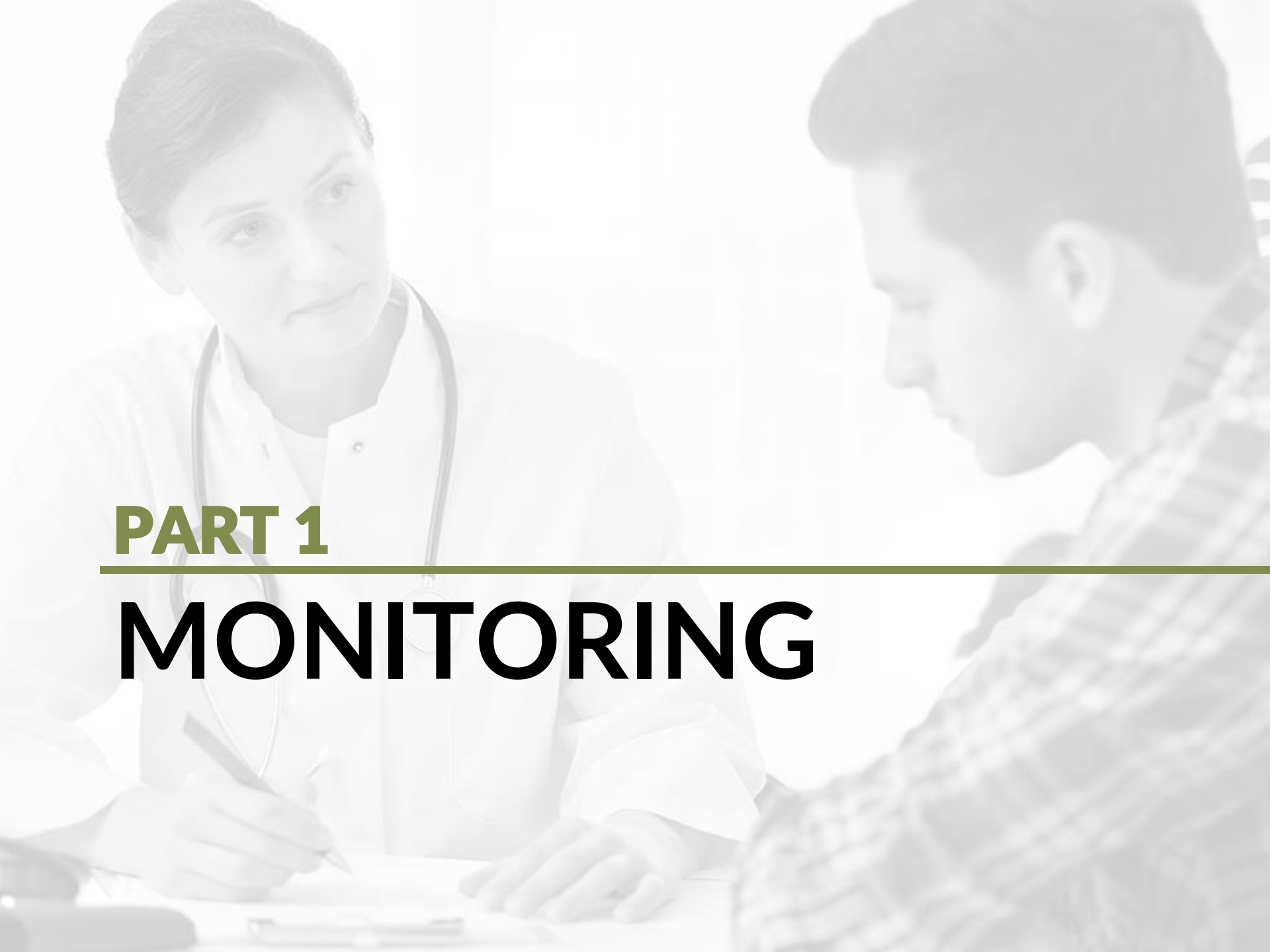
- Conduct a comprehensive and pain-focused history and physical
- Assess for risk of abuse and for mental health issues
- Determine if a therapeutic trial is appropriate
- Establish realistic goals for pain management and function
- Document EVERYTHING



CHAPTER 5

MANAGEMENT

MONITORING AND DISCONTINUING



PART 1

MONITORING

OPIOID SIDE EFFECTS

- Respiratory depression – most serious
- Opioid-Induced Constipation (OIC) – most common
- Sedation, cognitive impairment
- Falls and fractures
- Sweating, miosis, urinary retention
- Hypogonadism
- Tolerance, physical dependence, hyperalgesia
- Addiction in vulnerable patients

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

OPIOID-INDUCED RESPIRATORY DEPRESSION

Chief hazard of opioid agonists, including ER/LA opioids

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

Manifested by reduced urge to breathe and decreased respiration rate

- Shallow breathing
- CO_2 retention can exacerbate opioid sedating effects

Instruct patients/family members to call 911

Managed with

- Close observation
- Supportive measures
- Opioid antagonists
- Depending on patient's clinical status

SOURCE: Chou R, et al. *J Pain*. 2009;10:113-30.
FDA. *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics*. 01/2017. https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM515636.pdf

OPIOID-INDUCED RESPIRATORY DEPRESSION

MORE LIKELY TO OCCUR

- In elderly, cachectic, or debilitated patients
  - **Contraindicated** in patients with respiratory depression or conditions that increase risk
- If given concomitantly with other drugs that depress respiration
- Patients who are opioid-naïve or have just had a dose increase

REDUCE RISK

- Proper dosing and titration are essential
- **Do not overestimate** dose when converting dosage from another opioid product
  - Can result in fatal overdose with 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

WHEN TO MOVE FROM IR TO ER/LA OPIOIDS

PRIMARY REASONS

- Maintain stable blood levels (steady state plasma)
- Longer duration of action
- Multiple IR doses needed to achieve effective analgesia
- Poor analgesic efficacy despite dose titration
- Less sleep disruption

OTHER POTENTIAL REASONS

- Patient desire or need to try a new formulation
- Cost or insurance issues
- Adherence issues
- Change in clinical status requires an opioid with different pharmacokinetics
- Problematic drug-drug interactions

CONSIDERATIONS FOR CHANGE FROM IR TO ER/LA OPIOIDS

CO*RE

DRUG AND DOSE SELECTION IS CRITICAL

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 prescribing information)

MONITOR PATIENTS CLOSELY FOR RESPIRATORY DEPRESSION

Especially within 24-72 hours of initiating therapy and increasing dosage

INDIVIDUALIZE DOSAGE BY TITRATION BASED ON EFFICACY, TOLERABILITY, AND PRESENCE OF AEs

Check ER/LA opioid product PI for minimum titration intervals

Supplement with IR analgesics (opioids and non-opioid) if pain is not controlled during titration

SOURCE: The ER/LA Opioid Analgesics Risk Evaluation & Mitigation Strategy. *Selected Important Safety Information. Abuse potential & risk of life-threatening respiratory depression*. www.er-la-opioidrems.com/IwgUI/rems/pdf/important_safety_information.pdf. 2012. Chou R, et al. *J Pain.* 2009;10:113-30. FDA. *Blueprint for Prescriber Education for ER/LA Opioid Analgesics*. 06/2015. www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrug InformationforPatientsandProviders/UCM311290.pdf

OPIOID TOLERANCE

If opioid tolerant caution should still be used at higher doses

Patients considered opioid tolerant are taking at least

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

FOR 1 WEEK OR LONGER

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

SOURCE: The ER/LA Opioid Analgesics Risk Evaluation & Mitigation Strategy. *Selected Important Safety Information. Abuse potential & risk of life-threatening respiratory depression*. www.er-la-opioidrems.com/IwgUI/rems/pdf/important_safety_information.pdf. 2012.

OPIOID ROTATION

DEFINITION

Change from an existing opioid regimen to another opioid with 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 and AEs of different mu opioids vary among patients
- Patients show incomplete cross-tolerance to new opioid
  - Patient tolerant to first opioid can have improved analgesia from second opioid at a dose lower than calculated from an Equianalgesic Dosing Table (EDT)

SOURCE: 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.

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

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 (1.25-2.5 mg)	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 (0.2 mg)	1-2 mg q3-4hr (0.5-1 mg)

MU OPIOID RECEPTORS AND INCOMPLETE CROSS-TOLERANCE

MU OPIOIDS BIND TO MU RECEPTORS

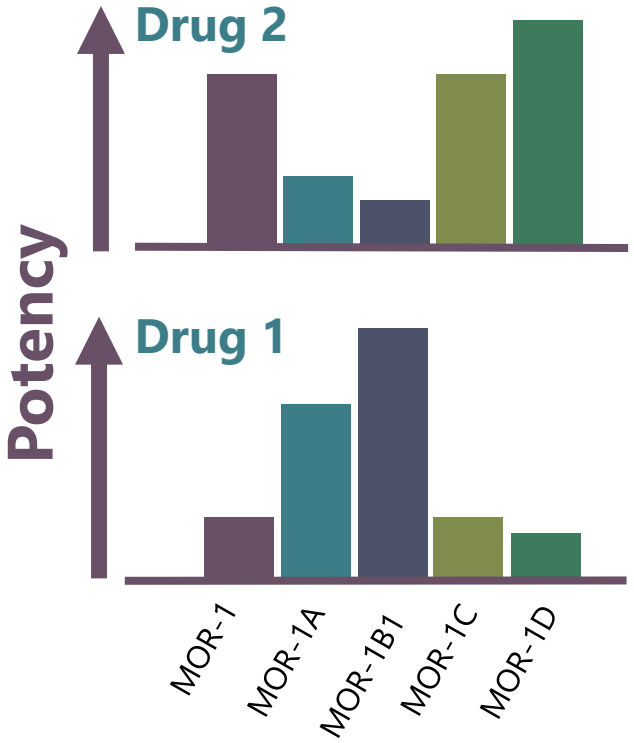
MANY MU RECEPTOR SUBTYPES:

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



GUIDELINES FOR OPIOID ROTATION

Calculate equianalgesic dose of new opioid from EDT

REDUCE CALCULATED EQUIANALGESIC DOSE BY 25%-50%*

SELECT % REDUCTION BASED ON CLINICAL JUDGMENT

CLOSER TO 50% REDUCTION IF PATIENT IS

- Receiving a relatively high dose of current opioid regimen
- Elderly or medically frail

CLOSER TO 25% REDUCTION IF PATIENT

- Does not have these characteristics
- Is changing route of administration

*75%-90% reduction for methadone

GUIDELINES FOR OPIOID ROTATION *(continued)*

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 PI
- **Buprenorphine**, follow instructions in the PI

BREAKTHROUGH PAIN (BTP)

PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP

- Disease progression or a new or unrelated pain
  - Target cause or precipitating factors
- Dose for BTP: using an IR is 5%-15% of total daily opioid dose, administered at an appropriate interval
- Never use ER/LA for BTP

CONSIDER ADDING

- 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
- Non-opioid drug therapies
- Non-pharmacologic treatments

ATC = Around the Clock

BE READY TO REFER

SUBSTANCE USE DISORDER

SAMHSA substance abuse treatment facility locator

https://findtreatment.samhsa.gov/locator/home

SAMHSA mental health treatment facility locator

https://findtreatment.samhsa.gov/locator/home

HIGH-RISK/COMPLEX PATIENTS

Refer to pain management, check state regulations for requirements

SAMHSA = Substance Abuse and Mental Health Service Administration

RATIONALE FOR URINE DRUG TESTING (UDT)

- Urine testing is done **FOR** the patient not **TO** the patient
- Help to identify drug misuse/addiction
- Assist in assessing and documenting adherence

UDT FREQUENCY IS BASED ON CLINICAL JUDGMENT AND STATE REGULATIONS

TYPES OF UDT METHODS

Be aware of what you are testing and not testing

IMMUNOASSAY (IA) DRUG PANELS

- Either lab-based or point of care
- Identify substance as present or absent according to cutoff
- Many do not identify individual drugs within a class
- Subject to cross-reactivity and variability

GC/MS OR LC/MS

- Identify the presence and quantity of substance(s)
- Identify drugs not included in IA tests
- When results are contested

GC/MS=gas chromatography/mass spectrometry - LC/MS=liquid chromatography/mass spectrometry

SOURCE: Melanson,S. Ptolemy, A.. Wasan, A. Professionalism and Commentary: Optimizing Urine Drug Testing for Monitoring Medication Compliance in Pain Management, In Pain Medicine, December 2013 14(12):1813-1820

SPECIFIC WINDOWS OF DRUG DETECTION

How long a person excretes drug and/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 and pH

For most drugs it is 1-3 days

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

URINE SPECIMEN INTEGRITY

SPECIMEN COLOR RELATED TO CONCENTRATION

Concentrated samples more reliable than dilute samples

TEMP WITHIN 4 MINUTES OF VOIDING IS 90-100°F

PH FLUCTUATES WITHIN RANGE OF 4.5-8.0

CREATININE VARIES WITH HYDRATION

Normal urine: >20 mg/dL	Dilute: creatinine <20 mg/dL and specific gravity <1.003	Creatinine <2 mg/dL not consistent with human urine

INTERPRETATION OF UDT RESULTS

POSTIVE RESULT

Demonstrates recent use

- Most drugs in urine have detection times of 1-3 days
- Chronic use of lipid-soluble drugs: test positive for ≥1 week

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

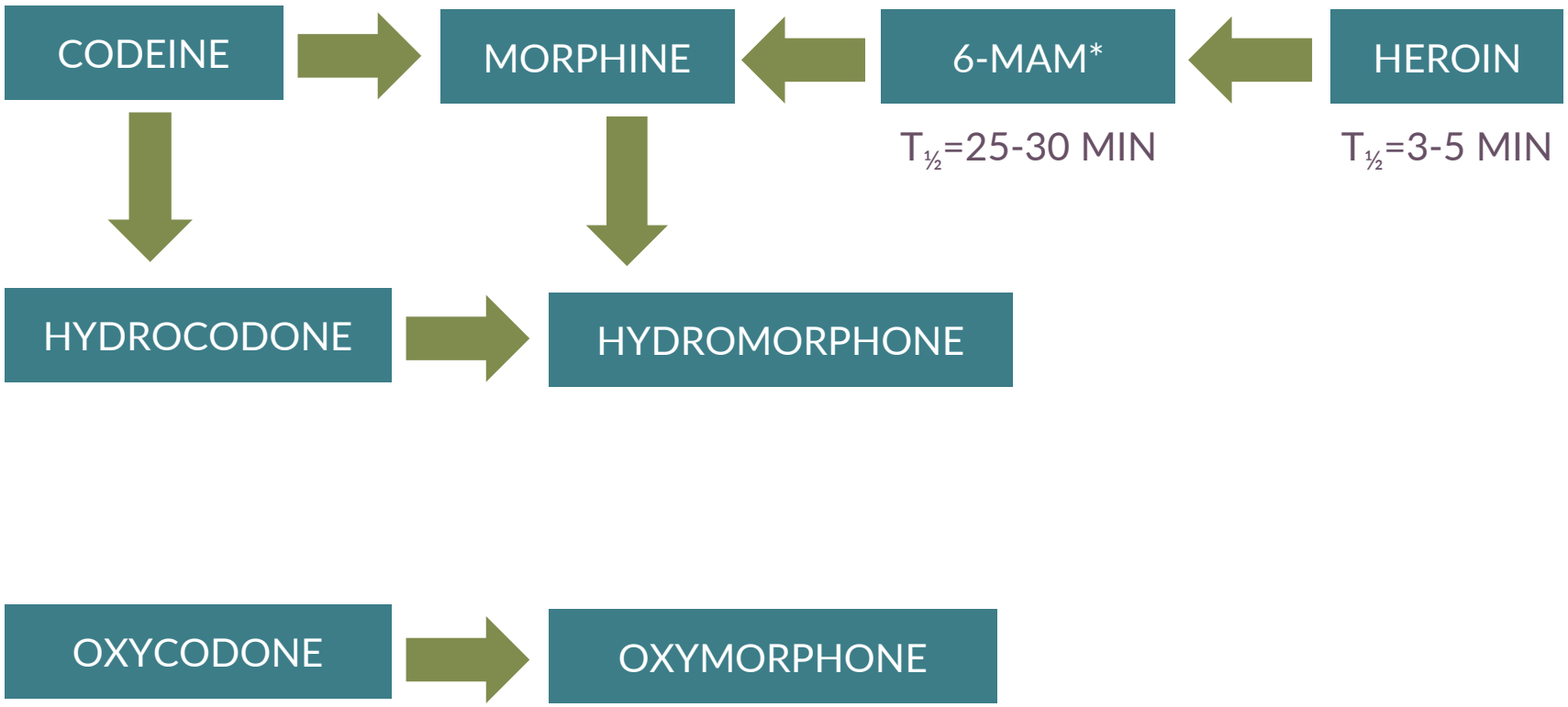
Does not diagnose diversion

- More complex than presence or absence of a drug in urine

May be due to maladaptive drug-taking behavior

- Binging, running out early
- Other factors: e.g., cessation of insurance, financial difficulties

EXAMPLES OF METABOLISM OF OPIOIDS



*6-MAM=6-MONOACETYLMORPHINE

RED FLAG:

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

Mrs. Lane and her family have been your patients for years. She has chronic headache and back pain treatment. When you ask her to take a UDT, she becomes upset and accuses you of not trusting her. You decide against further risk assessments because you are concerned about damaging the relationship.

Action:

Require all patients receiving opioids to follow a treatment plan and adhere to defined expectations. Create office policy for performing UDT for patients receiving opioids beyond two weeks. Practice universal precautions. Explain to patient that you must meet the standards of care that include evaluation of risk in all patients, use of PPAs, and other tools.

PART 2

DISCONTINUING

REASONS FOR DISCONTINUING OPIOIDS

PAIN LEVEL DECREASES IN STABLE PATIENTS

INTOLERABLE AND UNMANAGEABLE AEs

NO PROGRESS TOWARD THERAPEUTIC GOALS

MISUSE

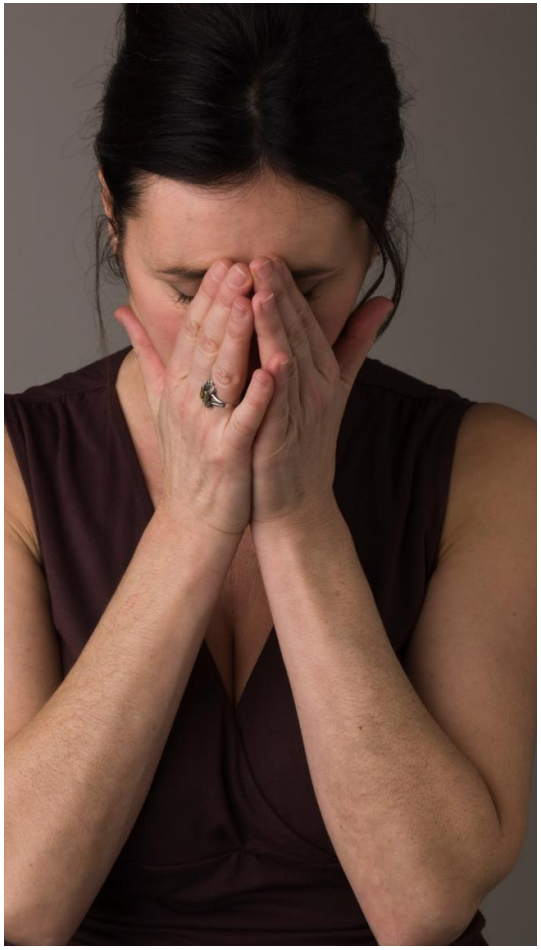
- 1 or 2 episodes of increasing dose without prescriber knowledge
- Sharing medications
- Unapproved opioid use to treat another symptom (e.g., insomnia)

ABERRANT BEHAVIORS

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

TAPER DOSE WHEN DISCONTINUING

- Minimize withdrawal symptoms in opioid-dependent patient, consider medications to assist with withdrawal
- May use a range of approaches from slow 10% dose reduction per week to more rapid 25%-50% reduction every few days
- If opioid use disorder or a failed taper, refer to addiction specialist or consider opioid agonist therapy
- Counseling and relaxation strategies needed



CHAPTER 5 – PEARLS FOR PRACTICE

- Establish informed consent and PPA at the beginning
- Educate the whole team: ***patients, families, caregivers***
- Refer if necessary
- Anticipate opioid-induced respiratory depression and constipation
- Follow patients closely during times of dose adjustments
- Periodically evaluate functional outcomes
- Discontinue opioids slowly and safely

CHALLENGE: IS THIS A LAB ERROR?

RED FLAG:

The questionable Urine Drug Test

Donald has been prescribed oxycodone for six months to treat back pain. His UDT at six months comes back negative in all areas. He tells you that he is taking his meds.

Action:

Do not discharge the patient as the first action. Contact the lab and discuss the test and any metabolite or specimen integrity issues. Ask: Is this the right lab test? Repeat the UDT and document everything. Discuss with the patient.

CHAPTER 6

SPECIAL POPULATIONS

OLDER ADULTS

RISK FOR RESPIRATORY DEPRESSION

- Age-related changes in distribution, metabolism, excretion; absorption less affected

MONITOR

  - Initiation and titration
  - Concomitant medications (polypharmacy)
  - Falls risk, cognitive change, psychosocial status
- Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients
- Start low, go slow, but GO
- Patient and caregiver reliability/risk of diversion

ROUTINELY INITIATE A BOWEL REGIMEN

SOURCE: 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.

WOMEN WITH CHILDBEARING POTENTIAL

KNOW THE REPRODUCTIVE PLANS AND PREGNANCY STATUS OF YOUR PATIENTS

- 40% of women with childbearing potential are prescribed opioids
- Opioid exposure during pregnancy causes increased risk for fetus
- Most women do not know they are pregnant in first few weeks
- Therefore all women of childbearing age are at risk
- No adequate nor well-controlled studies of opioids for pain in pregnancy

SOURCE: Ailes, E., Dawson, A., Lind, J., Bilboa, S., Frey, M., Broussard, C., Honein, M., MMWR 64(2015) "Opioid Prescription Claims Among Women of Reproductive Age – United Sates, 2008-2012

THE PREGNANT PATIENT

Potential risk of opioid therapy to the newborn is neonatal opioid withdrawal syndrome

GIVEN THESE POTENTIAL RISKS, CLINICIANS SHOULD:

- Counsel women of childbearing potential about risks and benefits of opioid therapy during pregnancy and after delivery
- Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks to fetus
- Refer to a high risk OB/Gyn who will ensure appropriate treatment for the baby

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

- If using opioids on a daily basis, consider methadone or buprenorphine

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

CHILDREN AND ADOLESCENTS: HANDLE WITH CARE

JUDICIOUS USE OF IR FOR BRIEF THERAPY

SAFETY AND EFFECTIVENESS OF MOST ER/LA OPIOIDS UNESTABLISHED

- Pediatric analgesic trials pose challenges
- Transdermal fentanyl approved in children aged ≥2 yrs
- Oxycodone ER dosing changes for children ≥11 yrs

ER/LA OPIOID INDICATIONS ARE PRIMARILY LIFE-LIMITING CONDITIONS

WHEN PRESCRIBING ER/LA OPIOIDS TO CHILDREN:

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

SOURCE: 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.

CHALLENGE: VULNERABILITY IN CO-DEPENDENT OLDER ADULTS

RED FLAG:

Questionable family diversion

78-year-old Thelma comes into clinic, accompanied by grandson, who is in the exam room with you and Thelma. Thelma says her oxycodone 10 mg tablets q 4 hours is no longer working for her back pain. She asks for more medicine. You ask grandson to leave the exam room so you can examine her privately.

Action: Based on exam findings and her request for more medication:

- UDT and PDMP check
- Discuss whether or not it is possible her grandson, or another family member, might be using her medications.
- Patient education: Do not give opioids to another person. Store in secure place – locked. Let you know if medications are not secure or if she feels any pressure about sharing medications.

CHAPTER 7

KNOW YOUR FEDERAL AND STATE LAWS

FEDERAL AND STATE REGULATIONS

Comply with federal and state laws and regulations that govern the use of opioid therapy for pain

FEDERAL

- Code of Federal Regulations, Title 21 Section 1306: rules governing the issuance and 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

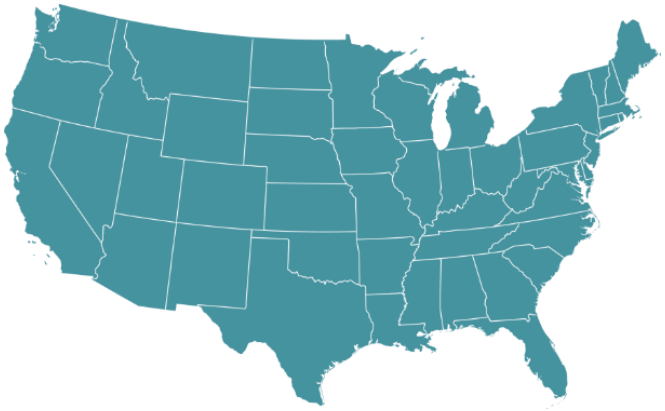
STATE

- Database of state statutes, regulations, and policies for pain management

  www.medscape.com/resource/pain/opioid-policies

  www.painpolicy.wisc.edu/database-statutes-regulations-other-policies-pain-management

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)



NOT ALL FEDERALLY LICENSED FACILITIES REPORT TO PDMPS

Link to state PDMP sites

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 with the PDMP
- Whether prescribers are required to access PDMP information in certain circumstances
- Whether unsolicited PDMP reports are sent to prescribers
- Bordering states may be available
- Designated surrogates may have access

PDMP BENEFITS

Provides full accounting of prescriptions filled by patient

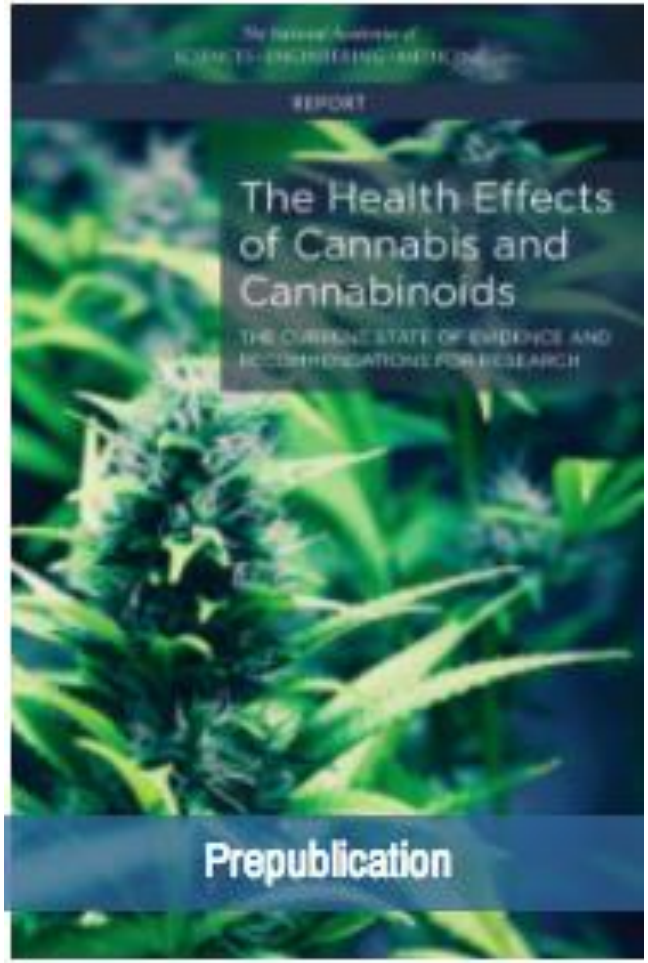
RECORD OF A PATIENT'S CONTROLLED SUBSTANCE PRESCRIPTIONS

- Some are available online 24/7
- Opportunity to discuss with patient

PROVIDE WARNINGS OF POTENTIAL MISUSE/ABUSE

- Existing prescriptions not reported by patient
- Multiple prescribers/pharmacies
- Drugs that increase overdose risk when taken together
- Patient pays with cash (vs insurance) for controlled meds

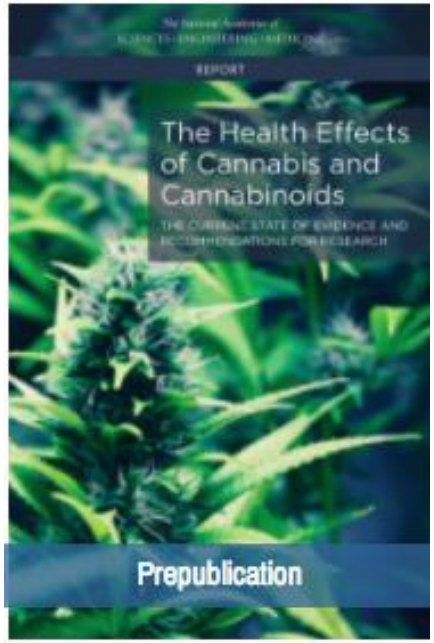
CANNABIS



- DEA Schedule 1 (“high abuse potential”) yet state laws and regulations vary
- There is evidence that cannabis or selective cannabinoids (cannabidiol) are effective for chronic pain treatment in adults
- More research is needed
- Concern for high risk groups: children, adolescents, pregnant women

SOURCE: The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. A National Academy of Science publication (2017)

CONSIDERATIONS FOR CLINICIANS



- Use available scientific evidence, advise patients
  - Inform about potential effects; AEs mostly mild and well tolerated (cough, anxiety)
  - Screen for potential misuse/abuse, diversion
- Set treatment goals, use PPA
- Encourage patients to keep notes, discuss with them
- Document everything
- Regular re-evaluation
- Consider periodic UDTs
- Discontinue if not helpful moving toward goals
- Edibles are the fastest growing delivery system
- No well controlled studies on the combined use of opioids and cannabis

SOURCE: The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. A National Academy of Science publication (2017)

CHALLENGE: THE HIGH RISK PATIENT

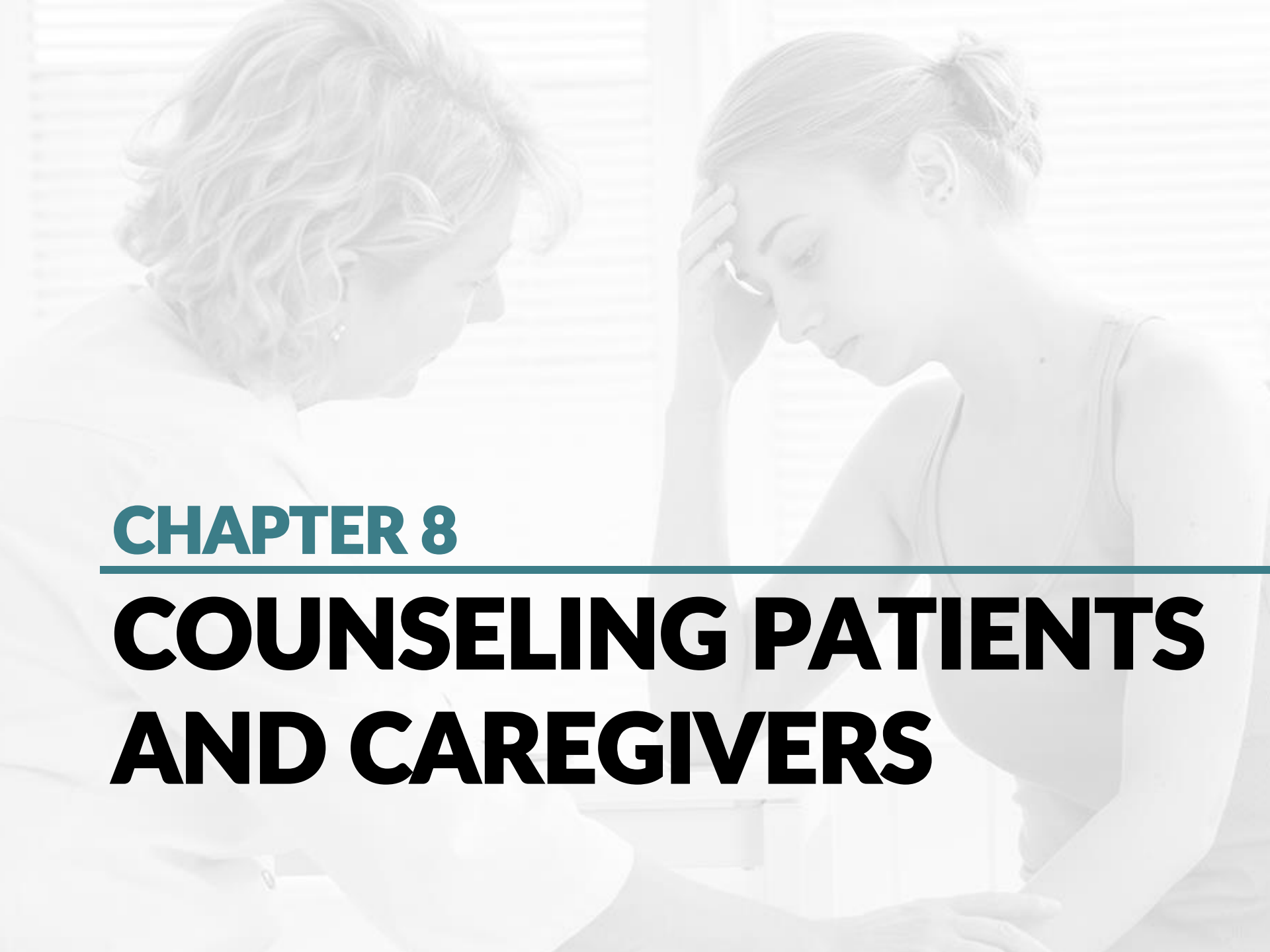
RED FLAG:

Proceed with caution, but treat the high risk patient

18-year-old with a recurrent wound in the antecubital fossa secondary to intravenous injection. This is her third wound debridement and she is in more pain than before. She tells you if she cannot get relief from you, she will go to the street for meds.

Action:

With a drug abuse history, proceed with caution and use extra safety measures. Patient may require admission to either hospital or treatment facility while managing pain. This history does not mean you should discharge or avoid treating the patient's pain.



CHAPTER 8

COUNSELING PATIENTS AND CAREGIVERS

USE PATIENT COUNSELING DOCUMENT

DOWNLOAD:
www.er-la-opioidrems.com/lwgUI/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'T:

- **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.

SOURCE: FDA. Extended-release (Er) And Long-acting (La) Opioid Analgesics Risk Evaluation And Mitigation Strategy (Rems). Modified 06/2015 www.fda.gov/downloads/ Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM311290.pdf

COUNSEL PATIENTS ABOUT PROPER USE

EXPLAIN

- Product-specific information about the IR or ER/LA opioid (especially when converting)
- Take opioid as prescribed
- Adhere to dose regimen
- How to handle missed doses
- Notify prescriber if pain not controlled
- Call prescriber for options on side effect management

INSTRUCT PATIENTS/ CAREGIVERS TO

- Read the ER/LA opioid **Medication Guide** received from pharmacy **every time** an ER/LA opioid is dispensed

COUNSEL PATIENTS ABOUT PROPER USE *(continued)*

EXPLAIN

- Inform prescriber of ALL meds being taken
- Warn patients not to abruptly discontinue or reduce dose
- Risk of falls
- Caution with operating heavy machinery and when driving
- Sharing or selling opioids can lead to others' deaths and is against the law

OPIOIDS CAN CAUSE DEATH EVEN WHEN TAKEN PROPERLY

- Signs/symptoms are respiratory depression, gastrointestinal obstruction, allergic reactions

COUNSEL PATIENTS ABOUT PROPER USE *(continued)*

EXPLAIN

- Tell patients and caregivers, medications must be kept in a locked container
- Will periodically assess for benefits, side effects, and continued need for IR/ER/LA opioids
- Need for re-evaluation of underlying medical condition if the clinical presentation changes over time

OPIOIDS SHOULD BE STORED IN A SAFE AND SECURE PLACE

- Away from children, family members, visitors, and pets
- Safe from theft

Opioids are scheduled under Controlled Substances Act and can be misused and abused

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 and death
- If unable to swallow a capsule whole, refer to PI to determine if appropriate to sprinkle contents on applesauce or administer via feeding tube

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

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

OVERDOSE POISONING, CALL 911

- Person cannot be aroused or awakened or is unable to talk
- Any trouble with breathing, heavy snoring is warning sign
- Gurgling noises coming from mouth or throat
- Body is limp, seems lifeless; face is pale, clammy
- Fingernails or lips turn blue/purple
- Slow, unusual heartbeat or stopped heartbeat

NALOXONE

Naloxone:

- An opioid antagonist administered by injection or intranasally, or IV
- Reverses acute opioid-induced respiratory depression but will also reverse analgesia

What to do:

- Discuss an 'overdose plan'
- Involve and train family, friends, partners, and/or caregivers
- Check with pharmacy if they are prescribing
- Check expiration dates and keep a viable dose on hand
- In the event of known or suspected overdose, administer naloxone and **call 911**

Available as:

- Naloxone kit (with syringes, needles)
- Injectable
- Nasal spray

Consider offering a naloxone prescription to all patients prescribed IR and ER/LA opioids

SOURCE: http://prescribetoprevent.org/wp2015/wp-content/uploads/CA.Detailing_Provider_final.pdf 2015

ABUSE-DETERRENT FORMULATION/TAMPER RESISTANT (ADF/TR) OPIOIDS

- Response to growing non-medical use problem
- An ER/LA opioid with physical barrier to *deter* extraction
  - Less likely to be crushed, injected, or snorted
- Consider as one part of an overall strategy
- Mixed evidence on the impact of ADF/TR on misuse
- Remember overdose is still possible if taken orally in excessive amounts

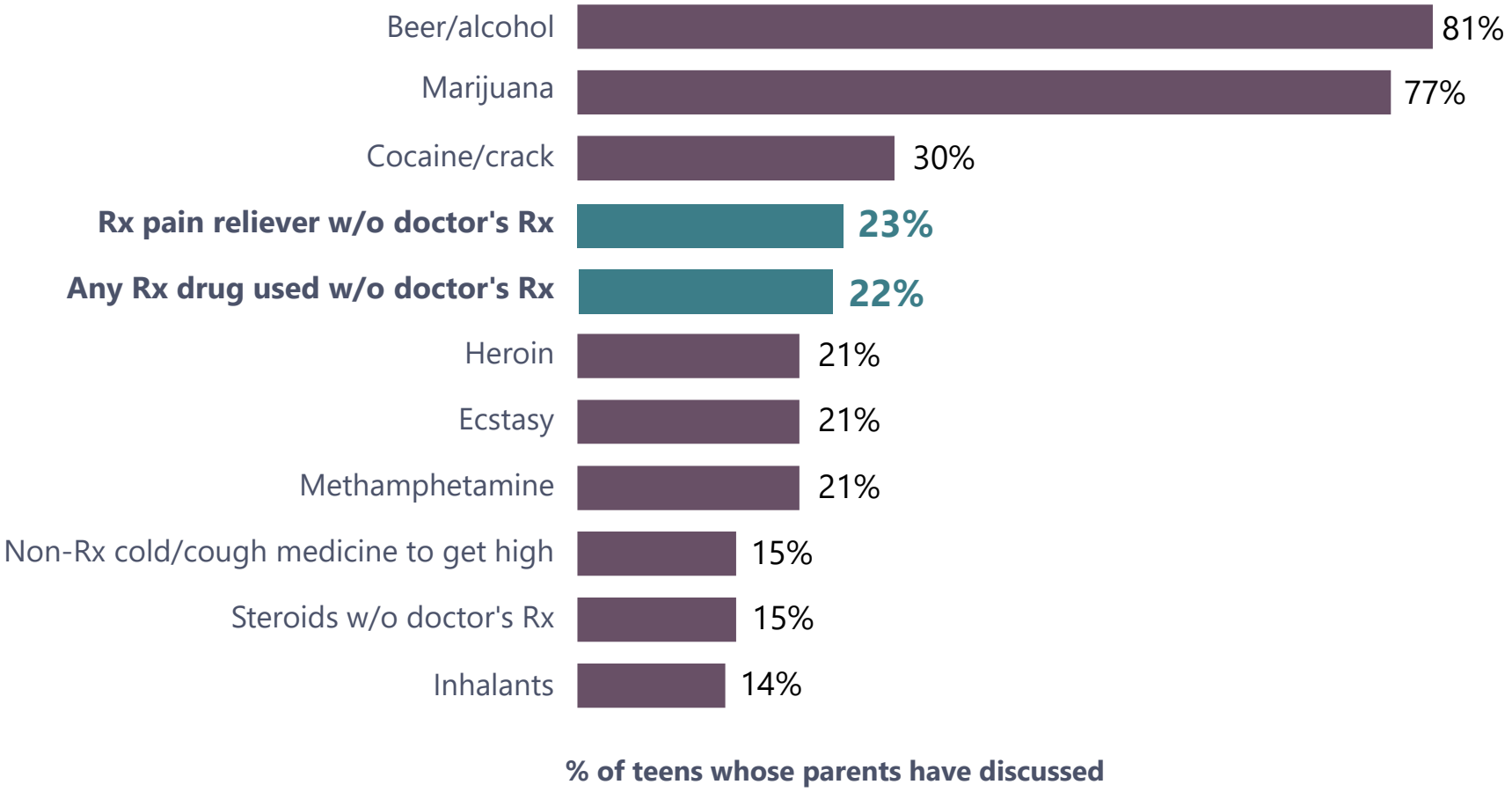
TALK WITH YOUR PATIENTS WHO ARE PARENTS

- Consider the behavior you are modeling
- 45% of parents have taken pain medications without a prescription at some point
- 14% have given their children pain medications without a prescription
- Teens report that their parents do not talk with them about prescription drug risks
    - Evidence suggests that pre-college parental conversation helps reduce high-risk substance abuse among college students

SOURCE: Turris,R., Mallett,K. Cleveland,M., Varvil-Weld,L., Abar,C., Scaglione N., Hultgren,B. J Stud Alcohol Drugs 74 (2013) "Evaluation of timing and dosage of a parent-based intervention to minimize college students' alcohol consumption" https://www.ncbi.nlm.nih.gov/pubmed/23200148

SUBSTANCES PARENTS HAVE DISCUSSED WITH TEENS*

*As reported by teens



REMEMBER…

STEP 1: MONITOR

- Note how many pills in each prescription
- Keep track of dosage and refills
- Make sure everyone in the home knows

STEP 2: SECURE

- Keep meds in a safe place (locked cabinet)
- Encourage parents of your teen's friends to secure their prescriptions

STEP 3: DISPOSE

- Discard expired or unused meds
- Consult PI for best disposal

SOURCE: McDonald E, Kennedy-Hendrick, A, McGinty E, Shields W, Barry C, Gielen A
AAP News, Pediatrics February 2017

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

Voluntarily maintained by:

- Law enforcement
- Authorized collectors, including:
  - Manufacturer
  - Distributor
  - Reverse distributor
  - Retail or hospital/clinic pharmacy
    - Including long-term care facilities

Look for local take-back events

- Conducted by Federal, State, tribal, or local law enforcement
- Partnering with community groups

SOURCE: 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 with undesirable substance
- Place in sealable bag, can, or other container
- Remove identifying info on label

FDA: PRESCRIPTION DRUG DISPOSAL

FLUSH DOWN SINK/TOILET IF NO COLLECTION RECEPTACLE, MAIL-BACK PROGRAM, OR TAKE-BACK EVENT AVAILABLE

- As soon as they are no longer needed
- Includes transdermal adhesive skin patches
  - Used patch (3 days) 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
  - Butrans (buprenorphine transdermal system)

    exception: can seal in Patch-Disposal Unit provided and dispose of in the trash

CHAPTER 8 – PEARLS FOR PRACTICE

- Use formal tools (PPAs, counseling document) to educate patients and caregivers
- Emphasize safe storage and disposal to patients and caregivers
- Consider co-prescribing naloxone

CHALLENGE: THE DAUGHTER'S PARTY

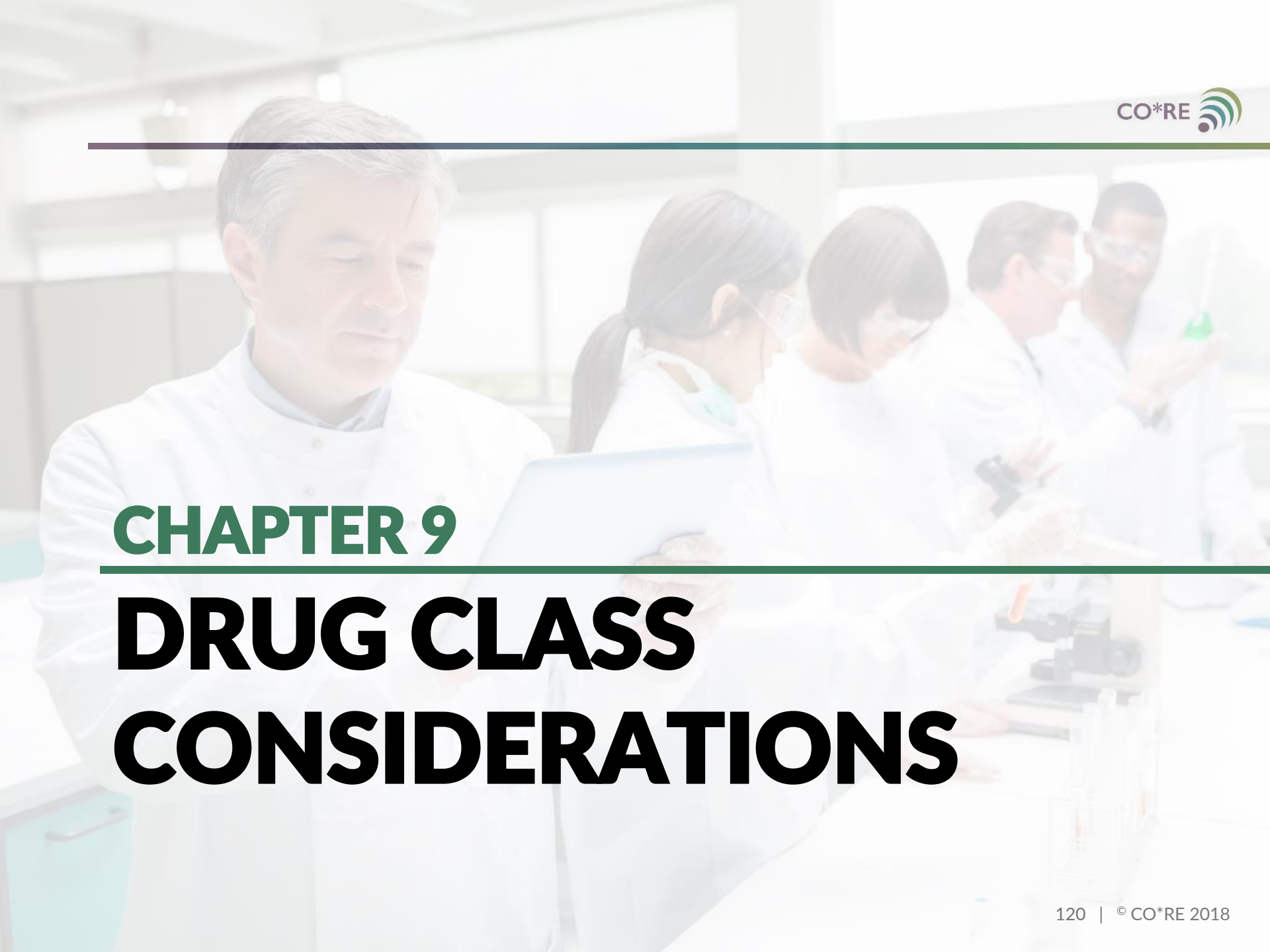
RED FLAG:

Patients do not safeguard their opioid medications correctly

Your patient's daughter 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 patients that taking another person's medication, even once, is against the law.



CHAPTER 9

DRUG CLASS CONSIDERATIONS

FOR SAFER USE: KNOW DRUG INTERACTIONS, PK, AND PD

CO*RE

CNS depressants can potentiate sedation and respiratory depression

Some ER/LA products rapidly release opioid (dose dump) when exposed to alcohol

Some drug levels may increase without dose dumping

Use with MAOIs may increase respiratory depression

Certain opioids with MAOIs can cause serotonin syndrome

Can reduce efficacy of diuretics

Inducing release of antidiuretic hormone

Methadone and buprenorphine can prolong QTc interval

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

TRANSDERMAL/TRANSMUCOSAL 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 with water

Monitor patients with fever for signs or symptoms of increased opioid exposure

Metal foil backings are not safe for use in MRIs

For buccal film products the film should not be applied if it is cut, damaged, or changed in anyway -- use entire film

DRUG INTERACTIONS COMMON TO OPIOIDS

- Concurrent use with 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 and/or precipitate withdrawal

- May enhance neuromuscular blocking action of skeletal muscle relaxants and increase respiratory depression

- Concurrent use with anticholinergic medication increases risk of urinary retention and severe constipation
- May lead to paralytic ileus

*Buprenorphine; †Pentazocine, nalbuphine, butorphanol

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

REVIEW

Annals of Internal Medicine

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction, although there are few studies for each of these outcomes; for some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk mitigation strategies is limited.

Limitations: Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. 2015;162:276-286. doi:10.7326/M14-2559 **www.annals.org**
For author affiliations, see end of text.
This article was published online first at www.annals.org on 13 January 2015.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

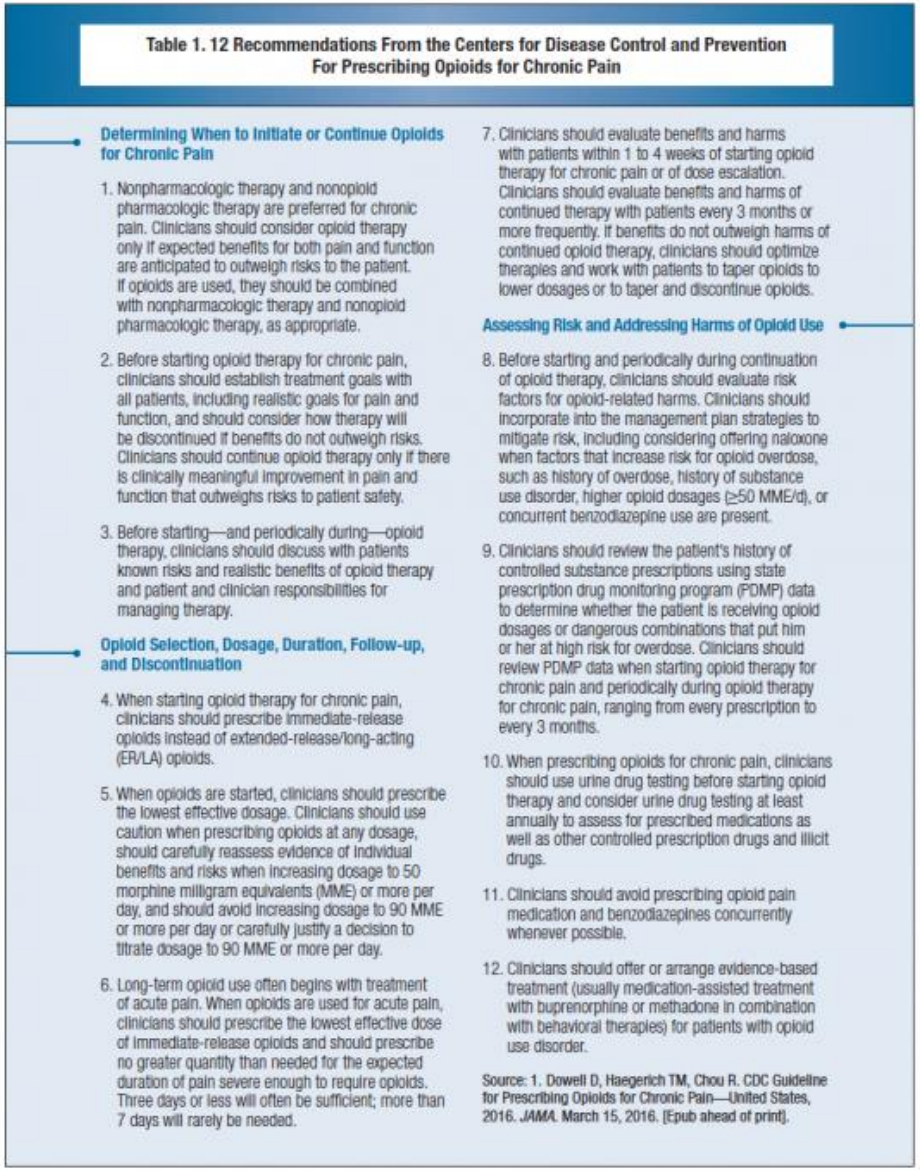


Table 1. 12 Recommendations From the Centers for Disease Control and Prevention For Prescribing Opioids for Chronic Pain

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting—and periodically during—opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

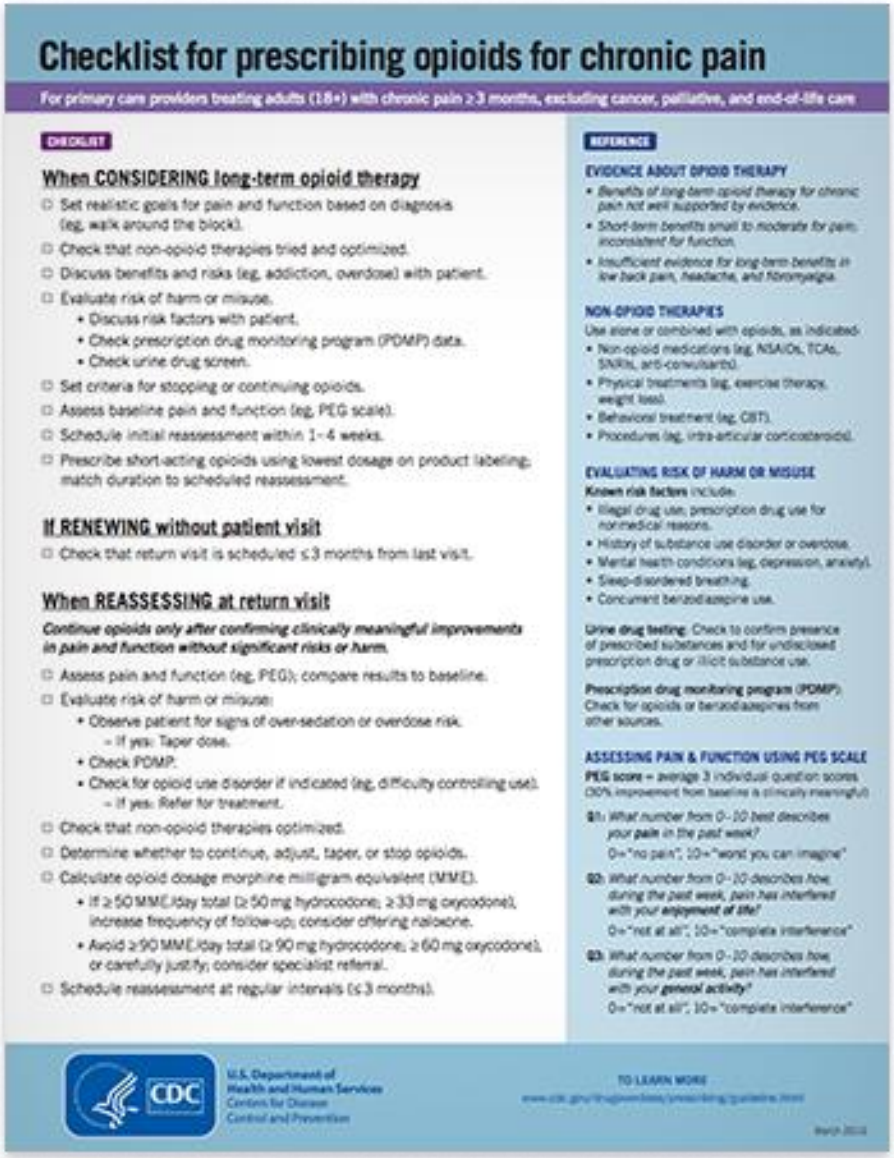
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Source: 1. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *JAMA*. March 15, 2016. [Epub ahead of print].

CDC CHRONIC PAIN GUIDELINE 3/16

- **Nonopioid** and **Nonpharmacologic** therapy is preferred
- Before starting opioid therapy, **establish realistic treatment goals**
- Before starting and periodically during opioid therapy, discuss **risks, benefits** and responsibilities for managing therapy
- **Immediate release opioids** should be used when starting therapy
- When opioids are started, **lowest effective dose** should be used
- Quantity prescribed: **acute pain < 3 days supply, rarely >7 days**
- **Evaluate benefit vs harm** in patient within 1-4 weeks of starting opioid therapy
- Before starting and during therapy, **evaluate risk factors**
- Review patient's history of controlled substance use by using the state's automated **prescription drug monitoring system (PDMP)**
- When prescribing opioids for chronic pain, clinicians should use **urine drug screens (UDS)**
- Avoid prescribing opioid medications with **benzodiazepines**
- Offer **substance use disorder treatment** for patients when needed

TOOLS AND MATERIALS



Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *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"

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

TO LEARN MORE

- **Provider and patient materials**
  - Checklist for prescribing opioids for chronic pain
  - Fact sheets
  - Posters
  - Web banners and badges
  - Social media web buttons and infographics
- **CDC Opioid Overdose Website**
  www.cdc.gov/drugoverdose/index.html

Our session stops here, but your review continues…

Refer to Appendix 1
for specific drug information on ER/LA opioid analgesic products

For detailed information, prescribers can refer to prescribing information available online via DailyMed at
www.dailymed.nlm.nih.gov
or Drugs@FDA at www.fda.gov/drugsatfda

YOUR PARTICIPATION IS 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!

ER/LA OPIOIDS REMS KNOWLEDGE TEST

1.) Among the risk factors contained in screening tools for predicting aberrant drug-related behavior in patients receiving opioids for chronic pain are family and personal history of substance abuse, legal problems, history of preadolescent sexual abuse, and psychological problems.

- A. Age (12-15 years)
- B. Age (16-45 years)
- C. Age (46-75 years)
- D. Age (≥ 76 years)
- E. Risk is even across age

2.) Which of the following is most important to consider when determining a starting dosage of an extended-release/long-acting opioid?

- A. Results of urine drug test
- B. Patient preference
- C. Cost of the medications
- D. Assessment of individual needs
- E. Starting dosage listed in the package insert

ER/LA OPIOIDS REMS KNOWLEDGE TEST

3.) A 55-year-old man who is being treated for chronic low back pain after undergoing laminectomy comes for follow-up evaluation. A trial of oxycodone ER therapy is planned. Completion of which of the following is the most appropriate step before initiation of therapy?

- A. Oswestry Disability Index
- B. Roland Morris Disability Questionnaire
- C. Patient-Prescriber Agreement
- D. MRI of the lumbar spine
- E. Routine blood tests

4.) A 63-year-old woman with a history of spinal stenosis and peripheral neuropathy secondary to breast cancer treatment comes for evaluation because of increasingly severe back pain. She reports that the pain started two weeks ago after doing yard work. She underwent chemotherapy 12 years ago. Medications include an opioid. Which of the following is the most appropriate next step?

- A. Assure the patient that the heightened sensitivity to pain is to be expected
- B. Reevaluate the underlying medical condition
- C. Refer the patient to physical therapy and administer a short-acting opioid as necessary
- D. Increase extended-release/long-acting opioid therapy dosage for up to one month
- E. Consider adding an adjuvant analgesic for neuropathic pain

ER/LA OPIOIDS REMS KNOWLEDGE TEST

5.) Use of ER/LA opioids in pediatric patients <18 years of age deserves special consideration because

- A. Safety & effectiveness of most ER/LA opioids has not been established in this population
- B. Many children experience chronic pain conditions with indications for ER/LA opioids
- C. Starting doses of opioids are reduced by one-third to one-half that in adults
- D. Opioid
- risk screening tools have not been validated in this population
- E. Many state laws require consultation with a pediatric pain specialist or pain clinic

6.) A 59 year-old with long-standing hypertension and Stage 3 chronic kidney disease continues treatment with disease-modifying anti-rheumatoid drugs (DMARDs) for rheumatoid arthritis (RA). Recently she has exhibited increasing pain and further functional decline likely due to progression of RA and osteoarthritis of the hips, knees and feet as well. She wants to remain as functional as possible. Which of the following is the best next step for addressing this patient's pain?

- A. Acetaminophen 650 mg two tabs q 4 hours prn
- B. Duloxetine 20 mg daily
- C. Oxycodone IR 5 mg q 4 hours prn
- D. Morphine sulfate ER 15 mg q 8 hours
- E. Ibuprofen 600 mg q 4 hours prn

ER/LA OPIOIDS REMS KNOWLEDGE TEST

7.) An inappropriate method to dispose of unused opioid medication is:

- A. Return the medication to a pharmacy
- B. Law enforcement drug take-back event
- C. Mix into cat litter before putting in the regular trash
- D. Dispose of medication in the regular trash
- E. Flush down the toilet

8.) The most important reason a patient should be counseled to never break, cut, chew, or crush a ER/LA opioid tablet or cut or tear patches is because:

- A. The medicine will expire
- B. It is against the law
- C. The dose will be less than prescribed
- D. The patient may die

ER/LA OPIOIDS REMS KNOWLEDGE TEST

9.) To avoid inadvertent overdose and death a patient should be counseled to avoid co-administration of an extended-release/long-acting opioid with which of the following?

- A. Alcohol
- B. Diphenhydramine
- C. St John's wort
- D. Aspirin
- E. Methamphetamine

10.) Which of the following extended-release/long-acting opioids is most likely to induce a peak respiratory depression that occurs later and persists longer than the analgesic effect?

- A. Fentanyl transdermal patch
- B. Hydromorphone ER
- C. Methadone
- D. Oxycodone CR
- E. Tapentadol ER

ER/LA OPIOIDS REMS KNOWLEDGE TEST

11.) When using an equianalgesic table to rotate opioids other than methadone, an important step to account for incomplete cross-tolerance among mu opioids includes:

- A. Initiate the new opioid at the calculated equianalgesic dose
- B. Increase the calculated equianalgesic dose by 10%-30%
- C. Reduce calculated equianalgesic dose by 25%-50%
- D. Convert and total all opioids to oral morphine equivalents
- E. Refer to the package insert for appropriate supplemental rescue dose

12.) A 72 year-old grandfather with severe persistent abdominal pain from colon cancer has been taking an immediate release opioid every four hours around the clock. He and his wife care for their two young grandchildren, and he states that he can no longer help with their care due to his pain level. He wants to increase the dose of his medication and asks what else he might do to control the pain. Which of the following supports the addition of an ER/LA opioid as treatment for this patient?

- A. More consistent plasma concentrations
- B. Fewer adverse events
- C. Less risk for respiratory depression with the addition of the ER/LA opioid
- D. Less need for ongoing monitoring

ER/LA OPIOIDS REMS KNOWLEDGE TEST

13.) A 67 year-old female with severe knee osteoarthritis has recently been converted from an immediate release opioid to an extended release opioid for pain control. She has chronic obstructive pulmonary disease that has made her a poor surgical candidate. In addition to extended release opioid, which second prescription would be the most appropriate to dispense to her?

- A. naloxone
- B. nortriptyline
- C. duloxetine
- D. acetaminophen

14.) A positive result of hydromorphone of a urine drug toxicology test for a patient on prescribed morphine can be interpreted as

- A. Use of heroin in past month
- B. Proof of supplemental hydromorphone
- C. Presence of the oxycodone metabolite
- D. Presence of the morphine metabolite
- E. Presence of semisynthetic opioids

Q&A

THANK YOU!

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MORPHINE SULFATE ER TABLETS (ARYMO ER)

Capsules 15 mg, 30 mg, 60 mg

Dosing interval	• Every 8 or 12 hours
Key instructions	• Initial dose in opioid-naïve and opioid non-tolerant patients is 15 mg every 8 or 12 hours • Dosage adjustment may be done every 1 to 2 days. • Take one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth
Drug interactions	• P-gp inhibitors (e.g. quinidine) can increase the exposure of morphine by about two-fold and increase risk of respiratory depression
Opioid-tolerant	• A single dose of ARYMO ER greater than 60 mg, or total daily dose greater than 120 mg, is for use in opioid-tolerant patients only.
Product-specific safety concerns	• Do not attempt to chew, crush, or dissolve. Swallow whole. • Use with caution in patients who have difficulty in swallowing or have underlying GI disorders that may predispose them to obstruction, such as a small gastrointestinal lumen.

MORPHINE SULFATE ER CAPSULES (AVINZA)

Capsules 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, and 120 mg

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

BUPRENORPHINE BUCCAL FILM (BELBUCA)

75 mcg, 150 mcg, 300 mcg, 450 mcg, 600 mcg, 750 mcg, and 900 mcg

Dosing interval	• Every 12 h (or once every 24 h for initiation in opioid naïve patients & patients taking less than 30 mg oral morphine sulfate eq
Key instructions	• Opioid-naïve pts or pts taking <30 mg oral morphine sulfate eq: Initiate treatment with a 75 mcg buccal film, once daily, or if tolerated, every 12 h - Titrate to 150 mcg every 12 h no earlier than 4 d after initiation - Individual titration to a dose that provides adequate analgesia and minimizes adverse reaction should proceed in increments of 150 mcg every 12 h, no more frequently than every 4 d • When converting from another opioid, first taper the current opioid to no more than 30 mg oral morphine sulfate eq/day prior to initiating Belbuca - If prior daily dose before taper was 30 mg to 89 mg oral morphine sulfate eq, initiate with 150 mcg dose every 12 h - If prior daily dose before taper was 90 mg to 160 mg oral morphine sulfate eq, initiate with 300 mcg dose every 12 h - Titration of the dose should proceed in increments of 150 mcg every 12 h, no more frequently than every 4 d

BUPRENORPHINE TRANSDERMAL SYSTEM (BUTRANS)

Transdermal System 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr

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

BUPRENORPHINE TRANSDERMAL SYSTEM (BUTRANS) *CONTINUED*

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
Product-specific safety concerns	• QTc prolongation & torsade de pointe • Hepatotoxicity • Application site skin reactions
Relative potency: oral morphine	• Equipotency to oral morphine not established

METHADONE HYDROCHLORIDE TABLETS (DOLOPHINE)

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 • Titrate slowly with dose increases no more frequent than every 3-5 d. Because of high variability in methadone metabolism, some patients may require substantially longer periods between dose increases (up to 12 d). • 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

METHADONE HYDROCHLORIDE TABLETS (DOLOPHINE) *CONTINUED*

Opioid-tolerant	• Refer to full PI
Product-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), *CONTINUED*

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
Product-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 (EMBEDA)

Capsules 20 mg/0.8 mg, 30 mg/1.2 mg, 50 mg/2 mg, 60 mg/2.4 mg, 80 mg, 3.2 mg, 100 mg/4 mg

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 (EXALGO)

ER Tablets 8 mg, 12 mg, 16 mg, 32 mg

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

HYDROCODONE BITARTRATE (HYSINGLA ER)

ER Tablets, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg, 120mg

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.

HYDROCODONE BITARTRATE (HYSINGLA ER) *CONTINUED*

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	• A single dose ≥ 80 mg is only for use in opioid tolerant patients.
Product-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 (KADIAN)

ER Capsules 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, 130mg, 150 mg, 200 mg

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, 130 mg, 150 mg, 200 mg capsules for use in opioid-tolerant patients only
Product-specific safety concerns	• None

MORPHINE SULFATE (MORPHABOND)

ER Tablets 15 mg, 30 mg, 60 mg, 100 mg

Dosing interval	• Every 8 h or every 12h
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)
Specific Drug interactions	• P-gp inhibitors (e.g. quinidine) may increase the absorption/exposure of morphine sulfate by about two-fold
Opioid-tolerant	• MorphaBond 100 mg tablets are for use in opioid-tolerant patients only
Product-specific safety concerns	• None

MORPHINE SULFATE (MS CONTIN)

ER Tablets 15 mg, 30 mg, 60 mg, 100 mg, 200mg

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 (NUCYNTA ER)

ER Tablets 50 mg, 100 mg, 150 mg, 200 mg, 250 mg

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 (OPANA ER)

ER Tablets 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg

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 (OXYCONTIN)

ER Tablets 10mg, 15mg, 20,mg, 30mg, 40mg, 60mg and 80 mg

NEW DOSING INFO

Dosing interval	• Every 12 h
Key instructions	• Initial dose in opioid-naïve and 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	• For Adults: 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 (OXYCONTIN) *continued*

IMPORTANT

CO*RE

ER Tablets 10mg, 15mg, 20,mg, 30mg, 40mg, 60mg and 80 mg

Key instructions	**For Adults**: • Single dose greater than 40 mg or total daily dose greater than 80 mg are for use in adult patients in whom tolerance to an opioid of comparable tolerance has been established. • When a dose increase is clinically indicated, the total daily oxycodone dose usually can be increased by 25% to 50% of the current dose. **For Pediatric Patients (11 years and older):** • For use only in opioid tolerant pediatric patients already receiving and tolerating opioids for at least five (5) consecutive days with a minimum of 20 mg per day of oxycodone or its equivalent for at least 2 days immediately preceding dosing with Oxycodone ER. Renal impairment (creatinine clearance <60 mL/min): start w/ ½ usual dosage • If needed, pediatric dose may be adjusted in 1 to 2 day intervals. • When a dose increase is clinically indicated, the total daily oxycodone dose usually can be increased by 25% of the current daily dose.
IMPORTANT:	• **Opioids are rarely indicated or used to treat pediatric patients with chronic pain.** • **The recent FDA approval for this oxycodone formulation was NOT intended to increase prescribing or use of this drug in pediatric pain treatment. Review the product information and adhere to best practices in the literature.**

OXYCODONE HYDROCHLORIDE/NALOXONE HYDROCHLORIDE (TARGINIQ ER)

ER Tablets 10 mg/5mg, 20 mg/10mg, 40 mg/20mg

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

OXYCODONE HYDROCHLORIDE/NALTREXONE HYDROCHLORIDE (TROXYCA ER)

ER Capsules 10/1.2mg, 20/2.4mg, 30/3.6mg, 40/4.8mg, 60/7.2mg, 80/9.6mg

Dosing interval	• Every 12 h
Key instructions	• Opioid-naïve & non-tolerant patient is 10/1.2mg, every 12h • Total daily dose may be adjusted by 20/2.4 mg every 2-3 d • Swallow capsules whole (do not chew, crush, or dissolve); possible fatal overdose, and naltrexone (possible withdrawal) • May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately • Do not administer through NG or G tube
Drug interactions	• CYP3A4 inhibitors may increase hydrocodone exposure • CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	• Single dose >40/4.8mg or total daily dose >80/9.6mg for use in opioid-tolerant patients only
Product-specific safety concerns	• None
Relative potency: oral morphine	• See individual product information for conversion recommendations from prior opioid

HYDROCODONE BITARTRATE (VANTRELA ER)

ER Tablets 15 mg, 30 mg, 45 mg, 60 mg, 90 mg

Dosing interval	• Every 12 h
Key instructions	• Initial dose in opioid naïve and non-tolerant patient is 15 mg every 12 h. Dose can be increased to next higher dose every 3-7 d • Swallow capsules whole (do not chew, crush, or dissolve) • Mild or moderate hepatic and moderate to severe renal impairment: initiate therapy with ½ recommended initial dose. If a dose <15 mg needed, use alternative options
Drug interactions	• CYP3A4 inhibitors may increase hydrocodone exposure • CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	• A 90 mg tablet, a single dose greater than 60 mg, or a total daily dose >120 mg are for use in opioid-tolerant patients only
Product-specific safety concerns	• None
Relative potency: oral morphine	• See individual product information for conversion recommendations from prior opioid

OXYCODONE (XTAMPZA ER)

ER Capsules 9 mg, 13.5 mg, 18 mg, 27 mg, 36 mg

Dosing interval	• Every 12 h
Key instructions	• Opioid naïve and non-tolerant, initiate with 9 mg every 12 h • Titrate using a minimum of 1-2 d intervals • Take with same amt of food in order to ensure consistent plasma levels • Maximum daily dose: 288 mg (8 x 36 mg), safety of excipients not established for higher doses • May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately • May also be administered through a NG or G feeding tube • Hepatic impairment: initiate therapy at 1/3 to ½ usual dose • Renal impairment: creatinine clearance <60 mL/min, follow conservative approach
Drug interactions	• CYP3A4 inhibitors may increase hydrocodone exposure • CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	• A single dose >36 mg or a total daily dose >72 mg for opioid-tolerant patients only
Product-specific safety concerns	• None
Relative potency: oral morphine	• There are no established conversion ratios for Xtampza ER, defined by clinical trials

NALOXONE (NARCAN)

Dosing interval	• IM or SQ: onset 2-5 minutes, duration >45 min • IV: onset 1-2 min, duration 45 minutes • IN: onset 2-3 min, duration ~ 2 hours
Key instructions	• Monitor respiratory rate • Monitor level of consciousness for 3-4 hours after expected peak of blood concentrations • Note that reversal of analgesia will occur
Drug interactions	• Larger doses required to reverse effects of buprenorphine, butorphanol, nalbuphine, or pentazocine
Opioid-tolerant	• Assess signs and symptoms of opioid withdrawal, may occur w-i 2 min – 2 hrs • Vomiting, restlessness, abdominal cramps, increased BP, temperature • Severity depends on naloxone dose, opioid involved & degree of dependence
Product-specific safety concerns	• Ventricular arrhythmias, hypertension, hypotension, nausea & vomiting • As naloxone plasma levels decrease, sedation from opioid overdose may increase

HYDROCODONE BITARTRATE (ZOHYDRO ER)

ER Capsules 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg

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

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