Patient Evaluation and Risk Stratification:

- Conduct a careful and thorough patient assessment and evaluation
- Seek consultation from a pain, psychiatry, addiction, or mental health specialist as needed
- Perform opioid risk assessment
  - Opioid Risk Tool (Appendix 4)
  - CAGE-AID Questionnaire (Appendix 5)
  - SOAPP-R (Appendix 7)
  - DIRE Instrument (Appendix 8)
  - Urine drug testing, CURES/PDMP report

Note: Although these assessments tools are well-established with proven effectiveness, providers must be aware that seasoned diverters know the right answers to these tools.

Informed Consent and Opioid Management Plans:

- Obtain a patient consent and a pain management agreement
- Establish and document treatment plan and goals with patient, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.
- Counsel patients on potential risks of opioid therapy
- Samples of pain management agreements:
  - AAPM Sample Agreement (Appendix 9)
  - Suggested Patient Medication Agreement and Consent (Appendix 10)
  - Suggested Treatment Plan Using Prescription Opioids (Appendix 11)
Initiating Opioid Trial:

- Consider safer alternative treatment before initiating opioid therapy. Consider opioid therapy only if expected benefits outweigh risks for patient
- When starting opioid therapy, prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- For acute pain, prescribe the lowest effective dose at no greater quantity than needed for the expected duration (i.e. three days or less)
- Start low and go slow
- Combine with nonpharmacologic therapy (e.g. psychotherapeutic co-intervention) and nonopioid pharmacologic therapy, as appropriate.
- Avoid concurrent benzodiazepine and opioid prescribing

Patient Education:

- Counsel patient on potential side effects, risks of opioid therapy, and danger signs of respiratory depression which require immediate medical attention
- Educate patient and caregiver on naloxone, and consider offering naloxone when there is an increased risk for opioid overdose such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

Ongoing Patient Assessment:

- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain
- Reassess patients on chronic opioid therapy regularly for clinical progress, absence of adverse events and compliance of pain management agreement
- If benefits do not outweigh harms of continue opioid therapy, consider tapering opioids to lower dosages or to discontinue opioids
- Conduct routine CURES/PDMP reports, drug testing and pill counting
- Refer to addiction medicine specialist or substance use disorder specialist/program if abuse is confirmed
- Contact police or DEA in event of prescription forgery and other criminal activity
High-Risk Patients:

- Identify patients at risk of substance abuse with screening assessment tools such as:
  - Current Opioid Misuse Measure (COMM)- (potential substance abuse problem) (Appendix 14)
  - Opioid Risk Tool (Appendix 4)
  - CAGE-AID Questionnaire (Appendix 5)
  - SOAPP-R (Appendix 7)
  - DIRE Instrument (Appendix 8)

- For patients at above-average risk of substance abuse, consider:
  - Conducting frequent and intense monitoring including CURES/PDMP and drug testing
  - Limiting prescription quantities
  - Collaborating with addiction specialist

2. Offer or arrange evidence-based treatment (e.g. buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

Dose Escalations, High-Dose Opioid Therapy, Opioid Rotation and Indications for Discontinuation of Therapy:

- Take caution when MED exceeds 80 mg/day by consulting appropriate specialists and close monitoring
- When MED reaches 50mg/day, increase frequency of follow-up, and consider offering naloxone
- Implement opioid rotation when pain relief is inadequate despite dose increase (e.g. opioid insensitivity or hyperalgesia), or intolerable adverse effects
- Establish a safely-structured tapering regimen or “exit strategy” when clinically indicated
  - Exit Strategy Guide (Appendix 16)
  - Suggested Strategies for Tapering and Weaning (Appendix 17)

Medical Records:

- Maintain adequate and accurate medical records, including thorough patient evaluation, opioid risk assessment, patient consent, pain management agreement, patient education, supporting documentation for opioid therapy, ongoing patient assessment, regular compliance monitoring, and prescription orders for controlled substances
Special Patient Populations:

- Individualize opioid therapy based on patient medical history, presentation of symptoms, and concurrent pharmacological therapy

Compliance with Controlled Substance Laws:

- Refer to the following sources to ensure legal use of COT in California
  - California laws regarding controlled substances
    - Health and Safety Code Section 11000-11033 (Reference 4)
  - Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons by the Medical Board of California (Reference 5)
  - Federal laws regarding controlled substances (Reference 6)
    - Title 21 United States Code (USC) Controlled Substances Act
  - Pharmacist corresponding responsibility (Reference 7)

Please refer to IEHP Pain Management Clinical Practice Guideline for additional information and appendix tools/guides.
IEHP Narcotic Drug Treatment Authorization Requirement

1. Please submit IEHP Prescription Prior Authorization (RX PA) for exceeding quantity limit, morphine equivalent daily dosage (MED) of 200mg or greater, and/or non-formulary narcotic drug request
2. Provide medical justification and document required for Rx PA clinical review as indicated below (see section I)

## I. IEHP Requirement for Opioid Analgesic Request

<table>
<thead>
<tr>
<th>Types of Rx PA Requests</th>
<th>Required Medical Documentation for Rx PA Review</th>
</tr>
</thead>
</table>
| MED < 200mg              | 1. Pain assessment  
                          | 2. Treatment plan and goal  
                          | 3. Pain Contract was signed  
                          | 4. Current and past analgesic drug regimen  
                          | 5. Any additional medical justification relevant to Rx PA request |
| MED ≥ 200mg              | All items on the IEHP Pain Assessment and Treatment Plan Form must be submitted with the Rx PA:  
                          | 1. Current and past analgesic drug regimen  
                          | 2. Pain contract was signed  
                          | 3. Documentation that risks and benefits of opioid therapy was discussed  
                          | 4. Documentation of opioid titration process to current pain regimen  
                          | 5. Adequate trial of optimal non-opioid analgesic drug regimen  
                          | 6. Recent CURES report was reviewed  
                          | 7. Recent urine drug screen result(s)  
                          | 8. Pain assessment  
                          | 9. Treatment plan and goal  
                          | 10. Plan for opioid discontinuation if benefits do not outweigh the risks  
                          | 11. History of substance abuse  
                          | 12. Any additional medical justification relevant to Rx PA request |
## II. IEHP Formulary Quantity Limit

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Generic Name</th>
<th>Schedule</th>
<th>Quantity Limit / 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tylenol W/Codeine</td>
<td>codeine/apap</td>
<td>III</td>
<td>90</td>
</tr>
<tr>
<td>Norco</td>
<td>hydrocodone/apap</td>
<td>II</td>
<td>90</td>
</tr>
<tr>
<td>Duragesic</td>
<td>fentanyl</td>
<td>II</td>
<td>10</td>
</tr>
<tr>
<td>MS Contin, Avinza, Kadian</td>
<td>morphine</td>
<td>II</td>
<td>60</td>
</tr>
<tr>
<td>Percocet</td>
<td>oxycodone/apap</td>
<td>II</td>
<td>90</td>
</tr>
<tr>
<td>Ultram</td>
<td>tramadol</td>
<td>VI</td>
<td>90</td>
</tr>
</tbody>
</table>

## III. Equianalgesic Chart

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Approximate Equianalgesic Dose (oral &amp; transdermal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine oral (chronic po)</td>
<td>30</td>
</tr>
<tr>
<td>Codeine oral</td>
<td>200</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
<td>0.2</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30</td>
</tr>
<tr>
<td>Hydromorphone oral</td>
<td>7.5</td>
</tr>
<tr>
<td>Methadone</td>
<td>10</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20</td>
</tr>
<tr>
<td>Oxymorphone oral</td>
<td>10</td>
</tr>
</tbody>
</table>

## IV. Recommended Dosage

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Recommended starting dose for opioid-naïve patients</th>
<th>Recommended dose threshold for pain consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl</td>
<td>Not recommended for opioid naïve patients</td>
<td>50 mcg/h (q72h)</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>5-10 mg q4-6h</td>
<td>80 mg per 24 hours</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2 mg q4-6h</td>
<td>20 mg per 24 hours</td>
</tr>
<tr>
<td>Methadone</td>
<td>2.5-5 mg bid-tid</td>
<td>20 mg per 24 hours</td>
</tr>
<tr>
<td>Morphine</td>
<td>IR: 10 mg q4h SR: 15 mg q12h</td>
<td>80 mg per 24 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>IR: 5 mg q4-6h SR: 10 mg q12h</td>
<td>55 mg per 24 hours</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>IR: 5-10 mg q4-6h SR: 10 mg q12h</td>
<td>30 mg per 24 hours</td>
</tr>
</tbody>
</table>
**Section A:**

**Member Medication Regimen**

<table>
<thead>
<tr>
<th>Current Analgesic Regimen:</th>
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</thead>
<tbody>
<tr>
<td>Drug Name</td>
<td>Strength</td>
<td>Frequency</td>
<td>Quantity</td>
<td>Duration</td>
<td>D/C date</td>
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</table>

<table>
<thead>
<tr>
<th>Past Analgesic Regimen (within last 6 months):</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Drug Name</td>
<td>Strength</td>
<td>Frequency</td>
<td>Quantity</td>
<td>Duration</td>
<td>D/C date</td>
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**Section B:**

**Supporting documents for current treatment plan.**

- Chart notes documenting titration up to current dose.
- Documentation indicating that the risk and benefits of opioid therapy have been discussed with the patient.
- Documentation indicating treatment plan for discontinuation if benefits do not outweigh the risks.
- Documentation indicating a Prescription Drug Monitoring Report (CURES) has been reviewed within the past 30 days.
  **Date CURES report was accessed:** _______
- Pain Contract signed and dated within the past 12 months.
  **Date Pain Contract was signed:** _______
- Urine Drug Screen within the past 6 months.
### IEHP Pain Assessment & Treatment Plan

**Patient Name:**

**Member ID:**

**Date of Birth:**

**Diagnosis**

---

**Date Urine Drug Screen was taken:** ______

**Results of test:** ______

---

#### Section C: Treatment Assessment Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient tried the most optimal non-opioid containing analgesic drug regimen?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the patient have any history of substance abuse?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, please identify the substance and past treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please provide any additional medical justification relevant to adding this medication to the patient’s pain regimen.</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

---

#### Section D: Pain Assessment (0 = no pain, 10 = worst pain)

**Current Pain:**

On a scale of 0-10, how would you assess patient’s current pain.

Please circle one: 0 1 2 3 4 5 6 7 8 9 10

Comments: ____________________________________________________________

**Treatment Goal:**

On a scale of 0-10, what is the pain scale goal for this patient.

Please circle one: 0 1 2 3 4 5 6 7 8 9 10

Comments: ____________________________________________________________

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Last Updated on 01/05/2017
References


