



A Public Entity

Inland Empire Health Plan

IEHP Pain Management Clinical Practice Guideline

Quick Reference Guide

(Last Updated February 2017)

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

Types of Rx PA Requests	Required Medical Documentation for Rx PA Review
MED < 200mg	<ol style="list-style-type: none"> 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	<p>All items on the IEHP Pain Assessment and Treatment Plan Form must be submitted with the Rx PA:</p> <ol style="list-style-type: none"> 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

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

III. Equianalgesic Chart

MED for Selected Opioids	
Opioid	Approximate Equianalgesic Dose (oral & transdermal)
Morphine oral (chronic po)	30
Codeine oral	200
Fentanyl transdermal	0.2
Hydrocodone	30
Hydromorphone oral	7.5
Methadone	10
Oxycodone	20
Oxymorphone oral	10

IV. Recommended Dosage

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

IEHP Pain Assessment & Treatment Plan

Patient Name:

Member ID:

Date of Birth:

Diagnosis

*****Please complete ALL sections of this form for further consideration. Incomplete forms will not be taken. *****

Section A: Member Medication Regimen					
Current Analgesic Regimen:					
Drug Name	Strength	Frequency	Quantity	Duration	D/C date
Past Analgesic Regimen (within last 6 months):					
Drug Name	Strength	Frequency	Quantity	Duration	D/C date

Section B: Supporting documents for current treatment plan.
<p><input type="checkbox"/> Chart notes documenting titration up to current dose.</p> <p><input type="checkbox"/> Documentation indicating that the risk and benefits of opioid therapy have been discussed with the patient.</p> <p><input type="checkbox"/> Documentation indicating treatment plan for discontinuation if benefits do not outweigh the risks.</p> <p><input type="checkbox"/> Documentation indicating a Prescription Drug Monitoring Report (CURES) has been reviewed within the past 30 days. Date CURES report was accessed: _____</p> <p><input type="checkbox"/> Pain Contract signed and dated within the past 12 months. Date Pain Contract was signed: _____</p> <p><input type="checkbox"/> Urine Drug Screen within the past 6 months.</p>

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	
Has the patient tried the most optimal non-opioid containing analgesic drug regimen?	Yes __ No__
Does the patient have any history of substance abuse? If yes, please identify the substance and past treatment	Yes __ No__
Please provide any additional medical justification relevant to adding this medication to the patient's pain regimen.	Yes __ No__

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: _____

References

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