# Model opioid prescribing policy

This model policy was developed using the CDC Guidelines for Prescribing Opioids for Chronic Pain and Washington State Opioid Prescribing Rules. It is an example that clinics can use when revising their policies.

**Revised**: DATE

**Next review date**: DATE

**Purpose**: To standardize prescribing guidelines for non-cancer opioid use.

**Scope**: This policy covers treatment of patients prescribed opioids for acute pain (0 to < 6 weeks), subacute pain (6 to 12 weeks), and chronic pain (> 12 weeks).

## Contents

The policy is separated into 5 sections and an appendix.

1. [SECTION 1](#_Section_1): Patients with acute pain (0 to < 6 weeks) and subacute pain (6 to < 12 weeks)

This refers to patients receiving opioids for pain that has occurred for less than 12 weeks.

1. [SECTION 2](#_Section_2): Patients whose pain is transitioning from subacute (6 to 12 weeks) to chronic (> 12 weeks)

This refers to patients receiving opioids for pain that are entering their 13th week of pain.

1. [SECTION 3](#_Section_3): Patients new to a panel who are already on long-term opioid therapy

This refers to patients that a clinician inherits from another clinician and who have received opioid therapy for more than 12 weeks.

1. [SECTION 4](#_Section_4): Existing clinic patients on long-term opioid therapy

This refers to a clinician’s existing patients who have received opioid therapy for more than 12 weeks.

1. SECTION 5: Existing clinic patients receiving opioids outside the practice

This refers to patients in your practice receiving opioids from a source outside the organization, such as a pain clinic or psychiatrity practice.

1. [SECTION](#_Section_5) 6: What to do in the case of concerning behaviors

This section pertains to patients who demonstrate concerning behaviors, such as repeated [aberrant behaviors](#_Aberrant_Behaviors), inappropriate behavior with staff or clinicians, diverting medication, or using non-prescribed substances that put the patient at risk.

1. [APPENDIX](#_Appendix:_Risk_Stratification): Risk stratification of patients receiving opioid therapy

This appendix provides guidance on how to risk stratify patients.

## Section 1

Patients with acute pain (0 to < 6 weeks) and sub-acute pain (6 to 12 weeks)

This section discusses guideline-consistent care processes for patients with pain lasting between 0 and 12 weeks.

General rules for opioid prescribing

* Only prescribe opioids if
* The patient has a diagnosis for pain that will benefit from opioid medication.
* It improves the patient’s function or pain.
* Prescribe the lowest effective dose of immediate-release opioids. Avoid doses of ≥50 MED.
* Do not prescribe opioids for non-specific axial (mechanical) low back pain, fibromyalgia, and chronic headaches.
* Do not refill opioid prescriptions without seeing the patient.
* Do not co-prescribe opioids and the following medications without documentation in the record, discussion of risks, consultation with the patient’s other prescribers, and consideration of tapering:
* Benzodiazepines, barbiturates, sedatives, carisoprodol, non-benzodiazepine hypnotics
* Encourage the use of evidence-based **non-opioid and non-pharmacological modalities** for acute and subacute pain whenever reasonable and clinically appropriate.
* The first time you prescribe opioids to a patient or when they transition from acute pain (0 to < 6 weeks) to subacute pain (6 to < 12 weeks):
* Re-evaluate the **patient’s history and physical examination**.
* Check the state prescription drug monitoring program (**PDMP**) to identify any medications received. If concerns are discovered when checking the PDMP, these must be documented in the patient record.
* Ensure that the patient has a **diagnosis** for their pain that will benefit from opioid medication. Document the diagnosis.
* Discuss **functional goals** for pain treatment.
* Document why the patient’s level of function or pain control **justifies continuation of opioids**.
* Provide patient with written notification and **educate** the patient about the risks associated with the use of opioids (including opioid dependence), how to securely store opioids; and about the availability and location of disposal sites for unused opioid medications. Document this notification in the patient record.
* When a patient transitions to subacute pain management, document in the patient record that the patient is now receiving subacute pain management.
* Prescribing 3 days or less of opioids will often be enough for acute pain (0 to < 6 weeks); **prescribe no greater than 7 days of opioids for acute pain. Do not prescribe methadone or extended-release opioids for acute pain**.
* Prescribe **no more than 14 days of opioids for subacute pain** (6 to < 12 weeks).
* **Assess for risk of overdose**. Risk factors for overdose include history of overdose, substance use disorder or abuse, sleep apnea, chronic lung disease, and use of any concurrent sedatives. See the [assessing risk section](#_How_to_measure) for how to assess.
* **Assess for** [aberrant behaviors](#_Aberrant_Behaviors) **and adverse events** (e.g., lost medications).
* If you identify a patient with **opioid use disorder**, discuss treatment with buprenorphine or a referral to an opioid treatment program for methadone. Also provide a referral to behavioral health services, if available.
* If the patient’s **function or pain is worsening**, do a urine drug test and check for [medical and behavioral health co-morbidities](#_Substance_use_disorder), such as PTSD, depression, and anxiety. See the [assessing risk section](#_How_to_measure) for how to assess.
* At every change in the opioid prescription:
* [Calculate](https://www.cdc.gov/drugoverdose/prescribing/app.html) morphine equivalent dose (**MED**).
* **Only continue an increased opioid dose if there is clinically meaningful improvement in pain and** [**function**](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Pain-Enjoyment-General-activity.pdf) **that outweighs risks to patient safety.**
* Avoid increasing dosage to ≥50 MED per day. If you do increase to ≥50 MED, document justification for this decision.
* Prescribe **naloxone** “rescue” (nasal or injectable) if the patient is prescribed ≥ 50 MED daily, is at risk for overdose, on [sedative medications](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf), has opioid use disorder, or is at risk of respiratory suppression due to sleep apnea or chronic lung disease. See the [assessing risk section](#_How__to) for how to assess.
* Document the **treatment plan**, including non-opioid and non-pharmacological modalities.
* If the patient is prescribed opioid medication at an MED ≥ 90, consider a **pain specialist consultation**. A pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose of opioids, or reasonable attempts to obtain consultation have failed.
* **Tapering** at 10% per week is reasonable for patients in the acute and subacute phase.
* Clinical documentation is needed for any deviation from these policies.

## Section 2

Patients transitioning from subacute to chronic pain

This section discusses guideline-consistent care processes for the first pain visit after a patient enters their 13th week of treatment for pain that includes opioid therapy. Conduct the following assessments ideally at the first chronic pain visit.

|  |  |
| --- | --- |
| What you are assessing | How to assess |
| Specific diagnosis for painCheck that the patient has a diagnosis for their pain that will benefit from opioid medication. | Based on history, physical examination, and testing (e.g., labs, imaging, as indicated) |
| Progress meeting functional goals  | [PEG](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Pain-Enjoyment-General-activity.pdf), documented [patient-set goals](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/02/Care-Plan_2019-02-20.pdf) (e.g., walk to the park), reports by family (though not always reliable, can be useful), evidence of performing job or life role function |
| Potential benefits of non-opioid therapies | Diagnosis, history, patient’s perspective, evidence (See [integrative medicine table](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/08/Complementary-and-Alternative-Medicine-for-Chronic-Pain_2018-08-13_new.pdf) and ["Nonopioid Treatments for Chronic Pain”](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/nonopioid_treatments-a.pdf)  |
| Risk  | * **Assess risk of opioid-induced morbidity or mortality** based on factors and combinations of factors such as [medical and behavioral comorbidities](#_Medical_and_behavioral), polypharmacy, current [substance use disorder or abuse](#_Substance_use_disorder), [aberrant behavior](#_Aberrant_Behaviors), [dose of opioids](#_Dose_of_opioids), or the use of [any concurrent sedatives](#_Use_of_any). Any patient using >90 MED per day is considered high risk.
* **Assess risk of overdose** based on history of overdose, [substance use disorder or abuse](#_Substance_use_disorder_1), sleep apnea, chronic lung disease, and use of any concurrent sedatives.

See the [assessing risk section](#_How__to) for details on how to assess.  |
| Current substances used, including [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) (e.g., benzodiazepines, carisoprodol) | [UDT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/CDC-DUIP-UrineDrugTesting_FactSheet-508.pdf)([Interpreting results](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Interpreting-UDT-results-information-sheet.pdf)) |
| Current medications filled, including [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) (e.g., benzodiazepines, carisoprodol) | [PDMP](#_Medications_taken/dose) |
| Morphine equivalent dosing | MED [calculator](https://www.cdc.gov/drugoverdose/prescribing/app.html) |
| Informed consent | Review the [patient agreement](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/10/Model-patient-agreement_2018-10-02.docx)  and have the patient sign it |
| Calculation of morphine equivalent dosing | MED [calculator](https://www.cdc.gov/drugoverdose/prescribing/app.html) |
| *If not done during acute or subacute pain period:* potential for substance/opioid misuse, abuse, or disorder | Potential tools to use: [ORT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Opioid_Risk_Tool.pdf), [ORT-OUD](http://core-rems.org/wp-content/uploads/2019/05/ORT-OUD-tool.pdf), [SOAPP](https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf), [COMM](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Current-Opioid-Misuse-Measure.pdf), [DAST](https://www.hca.wa.gov/assets/billers-and-providers/sbirt-screening-dast-en.docx), [TAPS](https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f), [DSM-5](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html) |
| *If not done in the past year:* assess for anxiety, depression | [PHQ](http://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Patient-Health-Questionnaire.pdf), [GAD-7](http://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/GAD-7.pdf); and, if elevated or suspected, consider [PTSD](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/PC-PTSD.pdf) screen |

### Other important care processes for patients transitioning into their 13th week of opioids

* Provide patient with written notification and **educate** patients about the risks associated with the use of opioids (including opioid dependence), how to securely store opioids; and about the availability and location of disposal sites for unused opioid medications.
* Prescribe **naloxone** “rescue” (nasal or injectable) if the patient is prescribed ≥ 50 MED daily, is at risk for overdose, on [sedative medications](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf), has opioid use disorder, or is at risk of respiratory suppression due to sleep apnea or chronic lung disease. See the [assessing risk section](#_How__to) for how to assess.
* If the patient is prescribed opioid medication at an MED ≥ 90, consider a **pain specialist consultation**. A pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose of opioids, or reasonable attempts to obtain consultation have failed.
* If you identify that a patient has **opioid use disorder**, discuss treatment with buprenorphine or a referral to an opioid treatment program for methadone. Also provide a referral to behavioral health services, if available.
* **Within 1 to 4 weeks of prescribing opioid therapy** for chronic pain, evaluate benefits and risks; ***only*** continue opioid therapy if there is clinically meaningful improvement in pain and function that outweighs risks to the patient.
* If appropriate, begin a [tapering protocol](https://www.improvingopioidcare.org/wp-content/uploads/2018/02/VA-Opioid-Taper-Decision-Tool.pdf) tailored to the patient. Slow opioid **tapers** (e.g., 10% per month or slower) as well as pauses in the taper with a defined resume time allow gradual accommodation to lower opioid dosages and are best practices. If a patient is enthusiastic about tapering, they can increase the taper rate (e.g., 10% every 2 weeks). Avoid increasing doses once tapering begins by identifying non-opioid strategies for pain flares. The only exception is a new acute pain problem.
* Be aware that unrecognized depression, anxiety and PTSD may be uncovered during a taper.

What to document in the patient record

* Transition from subacute pain (6 < 12 weeks) to chronic pain ((≥ 12 weeks)
* Risk level and related intervals for pain visits (high risk, at least quarterly; moderate risk, at least semiannually; low-risk, at least annually)
* Diagnosis for chronic pain
* Plan for treatment (e.g., physical therapy, non-opioid medications, opioid medication)
* Why the patient’s level of function or pain control justifies a continuation of opioids
* That you educated the patient about risks, storage, and safe disposal
* Patient agreement signed
* Concerns identified through checking the PDMP.
* Justification for:
* Co-prescribing benzodiazepines, barbiturates, sedatives, carisoprodol, or non-benzodiazepine hypnotics
* An opioid dosage ≥50 MED
* Any deviation from clinic policies

General rules for opioid prescribing

* Only prescribe opioids if
* The patient has a diagnosis for chronic pain that will benefit from opioid medication.
* It improves the patient’s function or pain.
* Prescribe the lowest effective dose of immediate-release opioids. Avoid doses of ≥50 MED.
* Do not prescribe opioids for non-specific axial (mechanical) low back pain, fibromyalgia, and chronic headaches.
* Do not refill opioid prescriptions without seeing the patient.
* Do not co-prescribe opioids and the following medications without discussion of risks, consultation with the patient’s other prescribers, and consideration of tapering:
* Benzodiazepines, barbiturates, sedatives, carisoprodol, non-benzodiazepine hypnotics

## Section 3

Patients new to a panel who are [already on long-term opioid therapy](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/02/Patients-on-legacy-prescriptions_2019-02-15.pdf)

This section discusses guideline-consistent care processes during the first 3 months after a patient already on long-term opioid therapy transfers to a new clinician. This could be a patient inherited after a clinician leaves the practice, or a patient new to the area. Whatever the circumstances, we encourage providers to accept patients already on long-term opioid therapy. These patients are at risk if left without evidence-based care.

When a patient already on long-term opioid therapy comes to you for care, conduct the following assessments as soon as possible, but always within 3 months.

|  |  |
| --- | --- |
| What you are assessing | How to assess |
| Care history | Obtain past medical records and ask why the patient terminated care with the last clinician. |
| Specific diagnosis for painCheck that the patient has a diagnosis for their pain that will benefit from opioid medication. | Based on history, physical examination, and testing (e.g., labs, imaging, as indicated). |
| Progress meeting functional goals  | [PEG](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Pain-Enjoyment-General-activity.pdf), documented [patient-set goals](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/02/Care-Plan_2019-02-20.pdf) (e.g., walk to the park), reports by family (though not always reliable, can be useful), evidence of performing job or life role function |
| Potential benefits of non-opioid therapies | Diagnosis, history, patient’s perspective, evidence (See [integrative medicine table](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/08/Complementary-and-Alternative-Medicine-for-Chronic-Pain_2018-08-13_new.pdf) and ["Nonopioid Treatments for Chronic Pain”](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/nonopioid_treatments-a.pdf)  |
| Risk  | * **Assess risk of opioid-induced morbidity or mortality** based on factors and combinations of factors such as [medical and behavioral comorbidities](#_Medical_and_behavioral), polypharmacy, current [substance use disorder or abuse](#_Substance_use_disorder), [aberrant behavior](#_Aberrant_Behaviors), [dose of opioids](#_Dose_of_opioids), or the use of [any concurrent sedatives](#_Use_of_any). Any patient using >90 MED per day is considered high risk.
* **Assess risk of overdose** based on history of overdose, [substance use disorder or abuse](#_Substance_use_disorder_1), sleep apnea, chronic lung disease, and use of any concurrent sedatives.

See the [assessing risk section](#_How__to) for details on how to assess.  |
| Potential for substance/opioid misuse, abuse, or disorder | Potential tools to use: [ORT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Opioid_Risk_Tool.pdf), [ORT-OUD](http://core-rems.org/wp-content/uploads/2019/05/ORT-OUD-tool.pdf), [SOAPP](https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf), [COMM](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Current-Opioid-Misuse-Measure.pdf), [DAST](https://www.hca.wa.gov/assets/billers-and-providers/sbirt-screening-dast-en.docx), [TAPS](https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f), [DSM-5](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html) |
| Current substances used, including [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) (e.g., benzodiazepines, carisoprodol) | [UDT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/CDC-DUIP-UrineDrugTesting_FactSheet-508.pdf)([Interpreting results](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Interpreting-UDT-results-information-sheet.pdf)) |
| Current medications filled, including [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) (e.g., benzodiazepines, carisoprodol) | [PDMP](#_Medications_taken/dose) |
| Morphine equivalent dosing | MED [calculator](https://www.cdc.gov/drugoverdose/prescribing/app.html) |
| Informed consent | Review the [patient agreement](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/10/Model-patient-agreement_2018-10-02.docx)  and have the patient sign it |
| Calculation of morphine equivalent dosing | MED [calculator](https://www.cdc.gov/drugoverdose/prescribing/app.html) |
| Anxiety, depression | [PHQ](http://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Patient-Health-Questionnaire.pdf), [GAD-7](http://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/GAD-7.pdf); and, if elevated or suspected, consider [PTSD](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/PC-PTSD.pdf) screen |

### Other important care processes for these patients

* Provide patient with written notification and **educate** patients about the risks associated with the use of opioids (including opioid dependence), how to securely store opioids; and about the availability and location of disposal sites for unused opioid medications.
* Prescribe **naloxone** “rescue” (nasal or injectable) if the patient is prescribed ≥ 50 MED daily, is at risk for overdose, on [sedative medications](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf), has opioid use disorder, or is at risk of respiratory suppression due to sleep apnea or chronic lung disease. See the [assessing risk section](#_How__to) for how to assess.
* If you identify a patient who has **opioid use disorder**, discuss treatment with buprenorphine or a referral to an opioid treatment program for methadone. Also provide a referral to behavioral health services, if available.

### Tapering

* If the patient is at an **opioid dose of ≥90 MED**, but their dose, pain, function, and compliance are stable, a pain consultation and tapering are not required for the first 3 months of prescribing.
* Evaluate when tapering or other adjustments in the treatment plan can or should be done.
* If appropriate, begin a [tapering protocol](https://www.improvingopioidcare.org/wp-content/uploads/2018/02/VA-Opioid-Taper-Decision-Tool.pdf) tailored to the patient by the end of the 3rd month of care. Slow opioid **tapers** (e.g., 10% per month or slower) as well as pauses in the taper with a defined resume time allow gradual accommodation to lower opioid dosages and are best practices. If a patient is enthusiastic about tapering, they can increase the taper rate (e.g., 10% every 2 weeks). Avoid increasing doses once tapering begins by identifying non-opioid strategies for pain flares. The only exception is a new acute pain problem.
* Be aware that unrecognized depression, anxiety and PTSD may be uncovered during a taper.
* If not tapering and the patient has an MED of 90 to 119 MED/day, consider a **pain specialist consultation**. After 3 months, a pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose of opioids, or reasonable attempts to obtain consultation have failed.
* If **co-prescribing** opioids and [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) for a patient, begin tapering when appropriate and within 3 months. Engage the patient in the process by deciding which to taper and at what rate. The tapering plan can change over time (e.g., which medicine is currently being tapered can alternate over time; tapering rate can change).
* If the patient chooses not to follow a tapering regimen and the clinician believes that **maintaining the current opioid dose is a significant health risk**, inform them that they will not continue to receive long-term opioid therapy. However, it is important to continue offering primary care to this patient.
* If the patient chooses not to follow a tapering regimen and the clinician believe that it is not a significant health risk to maintain the current opioid dose, the clinician can use clinical judgement and continue opioids. In this case, the clinician should broach the tapering conversation at every visit and document in the chart about the conversations.

What to document in the patient record

* [Risk level](#_Appendix_A:_Risk) and related intervals for pain visits (high risk, at least quarterly, moderate risk, at least semiannually; low-risk, at least annually)
* Diagnosis
* Plan for treatment (e.g., physical therapy, opioid medication)
* If a taper is not initiated by the end of the 3rd month of caring for the patient, why the patient’s level of function or pain control justifies continuing opioids
* That you educated the patient about risks, storage, and safe disposal
* Patient agreement signed
* Concerns identified through checking the PDMP
* Justification for:
* Co-prescribing benzodiazepines, barbiturates, sedatives, carisoprodol, or non-benzodiazepine hypnotics
* An opioid dosage ≥50 MED
* Any deviation from clinic policies

## Section 4

Existing clinic patients on long-term opioid therapy

This section covers how to provide guideline-consistent care for patients already in your practice on long-term opioid therapy.

General rules for opioid prescribing

* Only prescribe opioids if
* The patient has a diagnosis for chronic pain that will benefit from opioid medication.
* It improves the patient’s function or pain.
* Prescribe the lowest effective dose of immediate-release opioids. Avoid doses of ≥50 MED.
* Do not prescribe opioids for non-specific axial (mechanical) low back pain, fibromyalgia, and chronic headaches.
* Do not refill opioid prescriptions without seeing the patient.
* Do not co-prescribe opioids and the following medications without discussion of risks, consultation with the patient’s other prescribers, and consideration of tapering:
* Benzodiazepines, barbiturates, sedatives, carisoprodol, non-benzodiazepine hypnotics

### Opioid prescriptions for existing patients

* Do not provide an opioid refill until the patient has an up-to-date opioid **patient agreement, urine drug test, and prescription drug monitoring program** check. Refer to the [assessment schedule](#_Table_2:_Assessment) table for timing requirements.
* Consider writing **prescriptions for 28 day cycles** to avoid running out of medications on weekends.
* **Within 1 to 4 weeks of increasing opioid dosage**, evaluate benefits and risks; ***only*** continue increased dose if there is clinically meaningful improvement in pain and function that outweighs risks to the patient.
* If the patient has an MED of 90 to 119 MED/day, consider a **pain specialist consultation**. A pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose of opioids, or reasonable attempts to obtain consultation have failed.
* Patients should receive prescription refills from only **one clinician** (or their designee if not available).
* If reasonable, prescriptions should be refilled at a designated **single pharmacy**.
* Include **indications** for medication use on the prescription.
* Require that individuals **picking up an opioid prescription** in the clinic be designated and identifiable.
* Require **3 business days’ notice** for a medication refill.
* Do not refill opioids for **lost, stolen, spilled**, etc. medications except in extraordinary circumstances (e.g., fire, natural disaster, etc.).
* If patient has had a prior **overdose** occurrence, assess contributing factors; prior overdose is a high-risk factor for a repeat overdose event. Screen for alcohol use disorder, opioid use disorder, or other substance use disorder, and treat accordingly. If opioid use disorder is present, discuss with patient and arrange treatment with buprenorphine or methadone. Strongly consider dose reduction and prescribe naloxone.
* Do not prescribe opioids if a patient is **arrested or incarcerated** for selling prescription drugs.
* If you suspect **diversion**, carefully assess if the patient is taking the prescribed opioids by random urine drug testing and pill counts. If you believe diversion is occurring, do not prescribe opioids.

### Care processes for existing patients

* Set **chronic pain visit intervals** according to [risk level](#_Appendix_A:_Risk) (high risk, at least quarterly; moderate risk, at least semiannually; low-risk, at least annually)
* Conduct **patient assessments** according to the suggested opioid management [**assessment schedule**](#_Suggested_opioid_management)below.
* At least annually, or at every change in prescription, provide patient with written notification and **educate** patients about the risks associated with the use of opioids (including opioid dependence), how to securely store opioids; and about the availability and location of disposal sites for unused opioid medications.

What to document in the patient record

* [Risk level](#_Appendix_A:_Risk) and related intervals for pain visits (high risk, at least quarterly; moderate risk, at least semiannually; low-risk, at least annually)
* Diagnosis
* Plan for treatment (e.g., physical therapy, opioid medication)
* Why the patient’s level of function or pain control justifies a continuation of opioids
* That you educated the patient about risks, storage, and safe disposal
* Patient agreement signed
* Concerns identified through checking the PDMP
* Justification for:
* Co-prescribing benzodiazepines, barbiturates, sedatives, carisoprodol, or non-benzodiazepine hypnotics
* An opioid dosage ≥50 MED
* Any deviation from clinic policies
* If appropriate, begin a [tapering protocol](https://www.improvingopioidcare.org/wp-content/uploads/2018/02/VA-Opioid-Taper-Decision-Tool.pdf) tailored to the patient. Slow opioid **tapers** (e.g., 10% per month or slower) as well as pauses in the taper with a defined resume time allow gradual accommodation to lower opioid dosages and are best practices. If a patient is enthusiastic about tapering, they can increase the taper rate (e.g., 10% every 2 weeks). Avoid increasing doses once tapering begins by identifying non-opioid strategies for pain flares. The only exception is a new acute pain problem.
* If **co-prescribing** opioids and [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) for a patient, begin tapering when appropriate. Engage the patient in the process by deciding which to taper and at what rate. The tapering plan can change over time (e.g., which medicine is currently being tapered can alternate over time; tapering rate can change).
* Be aware that unrecognized depression, anxiety and PTSD may be uncovered during a taper.
* Prescribe **naloxone** “rescue” (nasal or injectable) if the patient is prescribed ≥ 50 MED daily, is at risk for overdose, on [sedative medications](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf), has opioid use disorder, or is at risk of respiratory suppression due to sleep apnea or chronic lung disease. See the [assessing risk section](#_How__to) for how to assess.
* If the patient is prescribed opioid medication at an MED ≥ 90, consider a **pain specialist consultation**. A pain specialist consultation is required at a dose of ≥ 120 MED/day unless the patient is following a tapering schedule, treatment is for short-term acute pain, pain and function are stable with a non-escalating dose of opioids, or reasonable attempts to obtain consultation have failed.
* **Within 1 to 4 weeks of increasing opioid doses**, evaluate benefits and risks; ***only*** continue increased dose if there is clinically meaningful improvement in pain and function that outweighs risks to the patient.
* If you identify a patient has **opioid use disorder**, discuss treatment with buprenorphine or a referral to an opioid treatment program for methadone. Also provide a referral behavioral health services, if available.

### Suggested opioid management assessment schedule

|  |  |  |
| --- | --- | --- |
| What you are assessing | How to assess | How frequently to assess |
| Specific diagnosis for painCheck that the patient has a diagnosis for their pain that will benefit from opioid medication. | Based on history, physical examination, and testing (e.g., labs, imaging, as indicated) | First acute, subacute, and chronic pain visit and then at visits [according to risk level](#_Appendix_A:_Risk) |
| Progress in meeting functional goals  | Pain, Enjoyment, General activity scale ([PEG](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Pain-Enjoyment-General-activity.pdf)), documented [patient-set goals](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2019/02/Care-Plan_2019-02-20.pdf) (e.g., walk to the park), reports by family (though not always reliable, can be useful), evidence of performing job or life role function | Every visit when opioids are prescribed |
| Potential benefits of non-opioid therapies | Diagnosis, history, patient’s perspective, evidence (See [integrative medicine table](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/08/Complementary-and-Alternative-Medicine-for-Chronic-Pain_2018-08-13_new.pdf) and ["Nonopioid Treatments for Chronic Pain”](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/nonopioid_treatments-a.pdf)  | First acute, subacute, and chronic pain opioid prescription visit and then at visits [according to risk level](#_Appendix:_Risk_Stratification) |
| Benefits and risks of continued opioid therapy | Based on history, [PEG](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Pain-Enjoyment-General-activity.pdf), [MED](https://www.cdc.gov/drugoverdose/prescribing/app.html), [COMM](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Current-Opioid-Misuse-Measure.pdf), [STOPBang](http://www.stopbang.ca/osa/screening.php), [PDMP](#_Dose_of_opioids), [UDT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/CDC-DUIP-UrineDrugTesting_FactSheet-508.pdf)  | A visit within 1 to 4 weeks of:* First chronic pain opioid prescription
* Increasing the dose of a chronic pain opioid prescription
 |
| Potential for substance/opioid misuse, abuse, or disorder | Potential tools to use: [ORT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Opioid_Risk_Tool.pdf)\*, [ORT-OUD](http://core-rems.org/wp-content/uploads/2019/05/ORT-OUD-tool.pdf)\*, [SOAPP](https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf), [COMM](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Current-Opioid-Misuse-Measure.pdf), [DAST](https://www.hca.wa.gov/assets/billers-and-providers/sbirt-screening-dast-en.docx), [TAPS](https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f), [DSM-5](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html) | First subacute or chronic pain visit |
| Current substances used, including [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) (e.g., benzodiazepines, carisoprodol) | [UDT](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/10/CDC-DUIP-UrineDrugTesting_FactSheet-508.pdf)([Interpreting results](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Interpreting-UDT-results-information-sheet.pdf)) | First subacute or chronic pain visit and then visits [according to risk level](#_Appendix:_Risk_Stratification) |
| Current medications filled, including [sedatives](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf) (e.g., benzodiazepines, carisoprodol) | [PDMP](#_Medications_taken/dose) | First opioid prescription, at each transition to a new pain category (acute, subacute, chronic), and then at visits [according to risk level](#_Appendix:_Risk_Stratification) |
| Informed consent | Review the [patient agreement](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/10/Model-patient-agreement_2018-10-02.docx)  and have the patient sign it | Start of long-term opioid therapy; annually |
| Morphine equivalent dosing | MED [calculator](https://www.cdc.gov/drugoverdose/prescribing/app.html) | First opioid prescription and every change in opioid prescription |
| Anxiety, depression | [PHQ](http://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Patient-Health-Questionnaire.pdf), [GAD-7](http://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/GAD-7.pdf) | [According to risk level](#_Appendix:_Risk_Stratification) |
| PTSD | [PC-PTSD](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/PC-PTSD.pdf) | If elevated PHQ or GAD despite active treatment |
| Sleep apnea | [STOPBang](http://www.stopbang.ca/osa/screening.php) (obstructive sleep apnea) [Epworth](http://healthysleep.med.harvard.edu/narcolepsy/diagnosing-narcolepsy/epworth-sleepiness-scale) (central sleep apnea) | When co-occurring risks: MED ≥ 50, Concurrent use of benzodiazepines , COPD, restrictive lung disease, including kyphosis or thoracic scoliosis, BMI > 28, snoring, fatigue, witnessed irregular breathing |
| Fibromyalgia | [Patient self-report tool](https://depts.washington.edu/fammed/improvingopioidcare/wp-content/uploads/sites/12/2018/02/Fibromyalgia-tool-and-article.pdf) | As appropriate if pain is widespread and co-occurring symptoms such as fatigue, poor sleep, depression, abdominal and/or urogenital pain during diagnosis |

\*Note: the ORT is validated for predicting risk of aberrant drug related behaviors while the ORT-OUD is validated for risk of developing opioid use disorder. See this [article](https://connect.aahpm.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=95b26ee4-b310-45b4-a946-aa8f29b498e9) for more information.

## Section 5

Existing clinic patients receiving opioids outside the practice

This section covers how to provide guideline-consistent care for patients in your practice receiving opioids from a source outside the organization, such as a pain clinic or psychiatric practice.

### Suggested approach to patients receiving opioids outside the practice

* If you identify a condition associated with a high risk of overdose when taking opioids, such as risk of respiratory suppression (e.g., sleep apnea, restrictive lung disease) or alcohol use disorder, and you know that the patient is using opioid medication prescribed by another provider, notify the opioid prescribing provider and document in the patient record.
* Before you prescribe a sedative, check the PDMP.  If the patient is receiving opioids, notify the opioid prescribing provider and document in the ​ patient record.
* Best practice is to also prescribe naloxone if ≥ 50 MED daily or if you think the patient is at risk for overdose.

## Section 6

What to do in the case of concerning behaviors

This section pertains to patients who demonstrate concerning behaviors, such as repeated [aberrant behaviors](#_Aberrant_Behaviors), inappropriate behavior with staff or clinicians, diversion of medication, or use of non-prescribed substances that put the patient at risk.

* In **all cases of concerning behavior**, meet with the patient, ask them to explain the behavior and assess for [opioid use disorder](#_Opioid_management_assessment) (e.g., thoughtful use of [DSM-5](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html) as described by the [CDC](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html)) or other [substance use disorders](#_Substance_use_misuse,).
* If you identify that a patient has **opioid use disorder**, discuss appropriate treatment choices and either provide buprenorphine treatment or a referral to an opioid treatment program for buprenorphine or methadone. Also provide a referral to behavioral health services, if available. If transferring to another location for care, make sure there is a “warm handoff” (e.g., by speaking directly with the accepting clinic to ensure the patient will be accepted or to make the first appointment).

### If a patient fails to present for a urine drug test:

* Make arrangements for another random urine drug test. Explain that this is the clinic’s standard procedure for prescribing opioids, and is required for all patients who receive opioid medications.
* If the patient fails to show a second time, contact the patient to let them know that they need to have a clinic visit with their assigned prescribing provider prior to their next opioid refill. If the patient does not come in for the requested visit before the time of the next opioid refill, notify the patient that no opioid refill is possible prior to meeting with their provider.

### When to begin a tapering protocol tailored to the patient with concerning behaviors

* Patients who have had repeated aberrant behaviors despite having met with their prescribing provider and been given the opportunity to change the behaviors, and the provider feels that he or she should no longer prescribe opioids.
* Patients with untreated sleep apnea, a recent overdose, or use of [concurrent nervous system depressants](#_Use_of_any).

### When to rapidly taper opioids

* Patients using substances that are very dangerous to mix with opioids, such as cocaine or methamphetamines.

### When to discontinue opioids immediately

* Patients diverting their prescribed opioids.

### When to discontinue health care

* In almost all cases, it is important to continue to provide health care to patients, even if you are no longer prescribing opioids.
* However, in some cases the organization might consider discontinuing health care to the patient, such as persistent, unacceptable, inappropriate behavior with staff or clinicians.

If opioids are terminated, a letter of opioid medication termination, including potential treatment options, is sent to the patient and a copy placed in the medical record. We encourage continuing to care for the patient’s chronic pain and primary care.

# Appendix: Risk Stratification and Opioid Prescribing

Washington State opioid prescribing rules suggest varying care for patients using long-term opioid therapy based on the patient’s risk of adverse outcomes. Assessing risk is best performed using professionally developed and clinically recommended risk assessment tools to assign patients to a high-, medium-, or low-risk category. The following resource helps primary care practices do this. The risk categories and care variance is based on the Washington State opioid prescribing rules.

## Risk categories

* **High risk**: This includes patients at high risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as [medical and behavioral comorbidities](#_Medical_and_behavioral), polypharmacy, current [substance use disorder or abuse](#_Substance_use_disorder), [aberrant behavior](#_Aberrant_Behaviors), [dose of opioids](#_Dose_of_opioids), or the use of [any concurrent sedatives](#_Use_of_any). Any patient using >90 MED per day is considered high risk.
* **Moderate risk**: This includes patients at moderate risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, history of substance use disorder or abuse, and aberrant behavior. In addition, any patient using 50-90 MED per day without other factors that increase their risk level is considered moderate risk.
* **Low risk:** This includes patients at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy. Patients must use <50 MED per day to qualify as low risk. However, some patients using <50 MED per day may be at moderate or high risk, based on other risk factors.

It is the responsibility of the medical provider prescribing opioid medication to identify the risk level of each patient and vary their care based on risk.

## How to vary care based on risk

|  |  |  |
| --- | --- | --- |
| Risk Category | Frequency of monitoring (visits, UDTs, PDMP checks) | Additional recommendations |
| High risk | Every 3 months | Consider referring to a pain specialist for additional evaluation and treatment needed to achieve treatment objectives. Confirm or provide a current prescription for naloxone when opioids are prescribed. |
| Moderate risk | Twice a year | Increase monitoring if any evidence of aberrant behavior. Confirm or provide a current prescription for naloxone when opioids are prescribed. |
| Low risk | Once a year | Increase monitoring if any evidence of aberrant behavior. |

## How to measure risk

*Below are suggested approaches to measuring different types of risks along with links to the tools.*

Risk factors for **opioid-induced morbidity or mortality** include [medical and behavioral comorbidities](#_Medical_and_behavioral), polypharmacy, current [substance use disorder or abuse](#_Substance_use_disorder), [aberrant behavior](#_Aberrant_Behaviors), [dose of opioids](#_Dose_of_opioids), or the use of [any concurrent sedatives](#_Use_of_any). Any patient using >90 MED per day is considered high risk.

Risk factors for **overdose** include history of overdose, substance use disorder or abuse, sleep apnea, chronic lung disease, and use of any concurrent sedatives.

### Medical comorbidities

* Sleep apnea, which can be screened for with [**STOPBang**](http://www.stopbang.ca/osa/screening.php) – an 8-item screener for sleep apnea.
* Chronic obstructive pulmonary disease (COPD)
* Fall risk
* Cognitive status
* Pregnancy
* Age 65+

### Behavioral comorbidities

* Substance use misuse, disorder, or abuse (see tools [below](#_Substance_use_disorder_1))
* Moderately severe or severe depression, which can be screened for initially with PHQ-4, then [PHQ-9](https://www.improvingopioidcare.org/wp-content/uploads/2018/02/Patient-Health-Questionnaire.pdf).
* Moderately severe or severe anxiety, which can be screened for initially with PHQ-4, then [GAD-7](https://www.improvingopioidcare.org/wp-content/uploads/2018/02/GAD-7.pdf).
* Post-traumatic stress disorder (PTSD), which can be screened for with the 4-item [**PC-PTSD**](https://www.improvingopioidcare.org/wp-content/uploads/2018/02/PC-PTSD.pdf): Primary Care PTSD Screen.
* Suicide ideation
* History of prior overdoses

### Substance/opioid misuse, abuse, or disorder

Each of the following tools has pros and cons. Select the tool/s that works best for you as a clinician.

* [**ORT**](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Opioid_Risk_Tool.pdf): Opioid Risk Tool – a 10-item screening tool for predicting opioid misuse in patients using opioid therapy.
* [**ORT-OUD**](http://core-rems.org/wp-content/uploads/2019/05/ORT-OUD-tool.pdf): an 8-item screening tool for predicting risk of developing opioid use disorder.
* [**SOAPP-r**](https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf): Screener and Opioid Assessment for Patients with Pain – a 14-item screening tool for predicting risk for developing problems among patients using long-term opioid therapy.
* [**COMM**](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/Current-Opioid-Misuse-Measure.pdf): Current Opioid Misuse Measure – a 17-item screening tool to help clinicians identify if a patient is exhibiting aberrant behaviors associated with misuse of opioid medications.
* [**DAST-10**](https://www.hca.wa.gov/assets/billers-and-providers/sbirt-screening-dast-en.docx): The Drug Abuse Screening Test – a 10-item brief screening tool commonly used to assess for substance use, not including alcohol or tobacco in the past 12 months.
* [**TAPS**](https://cde.drugabuse.gov/instrument/29b23e2e-e266-f095-e050-bb89ad43472f): The Tobacco, Alcohol, Prescription medications, and other Substance Tool – a 4-item screening tool to assess tobacco, alcohol, illicit drugs, and non-medical use of prescription medications.
* [DSM-5](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html): DSM-5 may be used to diagnose opioid use disorder, but be thoughtful in its use with patients on long-term opioid therapy. See the [CDC](https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html) for more details.

### [Aberrant behaviors](https://www.drugabuse.gov/sites/default/files/files/AberrantDrugTakingBehaviors.pdf)

* Resistance to changing opioid medications despite deterioration in function or significant negative effects
* Use of illegal drugs or controlled substances that are not prescribed for the patient (self-report or [**urine drug test**](https://www.improvingopioidcare.org/wp-content/uploads/2018/10/CDC-DUIP-UrineDrugTesting_FactSheet-508.pdf))
* Behaviors suggesting loss of control over substance use or diversion, such as recurrent episodes of:
* Prescription loss or theft
* Obtaining opioids from other providers in violation of treatment agreement (identified through review of [**State Prescription Drug Monitoring Database Programs**](http://www.pdmpassist.org/content/state-pdmp-websites))
* Increases in dosing without provider’s instruction (self-report)
* Running short with medication supply and requests for early refills

### Medications taken/dose

* [**Morphine Equivalent Dose (MED) calculator**](https://www.cdc.gov/drugoverdose/prescribing/app.html)
* [**State Prescription Drug Monitoring Database Programs**](http://www.pdmpassist.org/content/state-pdmp-websites)

### Use of any concurrent sedatives

* [**Sedatives list**](https://depts.washington.edu/fammed/sixbuildingblocks/wp-content/uploads/sites/12/2018/02/List-of-sedatives-names.pdf): A list of sedatives to use in identifying patients on concurrent sedatives and opioids.