Guideline Summary NGC-7902

Guideline Title

Interagency guideline on opioid dosing for chronic non-cancer pain: an educational aid to improve care and safety with opioid therapy.

Bibliographic Source(s)


Guideline Status

This is the current release of the guideline.


Scope

Disease/Condition(s)

Chronic non-cancer pain

Guideline Category

Evaluation
Management
Risk Assessment
Screening
Treatment

Clinical Specialty

Anesthesiology
Emergency Medicine
Family Practice
Geriatrics
Internal Medicine
Neurology
Orthopedic Surgery
Pharmacology
Physical Medicine and Rehabilitation
Psychology
Surgery

Intended Users

Advanced Practice Nurses
Nurses
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments
Substance Use Disorders Treatment Providers

Guideline Objective(s)
- To assist the primary care provider in prescribing opioids for adults in a safe and effective manner when:
  - Instituting or transitioning opioid therapy from acute to chronic non-cancer pain
  - Assessing and monitoring opioid treatment for chronic non-cancer pain
  - Tapering or discontinuing opioids if an opioid trial fails to yield improvements in function and pain
- To assist primary care providers in optimizing treatment when:
  - Assessing effectiveness of opioid therapy in patients who exceed 120 mg morphine equivalent dose (MED)/day
  - Reducing the total daily opioid dose
  - Discontinuing opioid therapy

Target Population
Adults with chronic non-cancer pain who receive healthcare through state agency programs

Note: The guideline does not apply to patients with acute pain, cancer pain, and end-of-life (hospice) care.

Interventions and Practices Considered

Evaluation
1. Assessing risks and benefits of opioid treatment (using screening tools such as Opioid Risk Tool [ORT], CAGE-AID, Patient Health Questionnaire [PHQ-9], etc., for risk factors)
2. Assessing effects of treatment using tools that monitor function and pain (e.g., SF36 Health Survey, QuickDash, Quality of Life Scale, etc.)
3. Urine drug testing

Management/Treatment
1. Instituting opioid treatment including calculation of morphine equivalent dose (MED)
2. Monitoring for tolerance and adverse effects
3. Specialty and pain management consultation
4. Tapering opioids
5. Managing behavioral issues during tapering
6. Referrals for addiction management or opioid agonist treatment
7. Emergency department guidance on drug seeking behavior and coordinating patient care

Major Outcomes Considered
- Functional improvement
- Pain relief
- Safety and efficacy of opioid use
- Adverse outcomes of opioid use

Methodology

Methods Used to Collect/Select the Evidence
Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence
The Cochrane and Medline databases were searched. Key words: opioids and hyperalgesia, opioid analgesic tolerance, opioid tolerance and respiratory depression, functional assessment, opioid detoxification.

Number of Source Documents
123 documents were reviewed.

Methods Used to Assess the Quality and Strength of the Evidence
Expert Consensus (Committee)

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Advisors from both the private and public sectors provided crucial consultation and input to this guideline. These advisors included state health officials and actively practicing physicians who specialize in pain management. Their clinical, scientific, and technical expertise helped ensure that this guideline would be relevant, accurate, and of practical use to prescribers. Every effort was made to create a guideline as evidence-based as possible. Where scientific evidence was insufficient or unavailable, the best clinical opinions and consensus of the advisory group were used.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Members of various boards and commissions reviewed the guidelines and asked clarifying questions that were addressed by participating pain specialists and the interagency work group, under the guidance of the Agency Medical Directors' Group.

The guideline was further refined after input from other community-based practicing physicians and the University of Washington.

In addition, the guideline was compared with guidelines from the following organizations:


Recommendations

Major Recommendations

Guidelines for Initiating, Transitioning, and Maintaining Oral Opioids for Chronic Non-Cancer Pain

Dosing Threshold for Pain Consultation

The hallmark of this guideline is a recommendation to not prescribe more than an average daily morphine equivalent dose (MED) of 120 mg without either the patient demonstrating improvement in function and pain or first obtaining a
consultation from a pain management expert.

This guideline provides a calculator for determining a patient’s daily MED, and a calculator for when the patient needs an opioid taper plan. For patients on doses higher than 120 mg MED this guideline also provides recommendations for optimizing treatment. Resources for calculating MED when patients are on one or more opioids can be found in Appendix A of the original guideline document.

Available evidence supports the following recommendations:

- The total daily dose of opioids should not be increased above 120 mg oral MED without either the patient demonstrating improvement in function and pain or first obtaining a consultation from a practitioner qualified in chronic pain management.
- Risks substantially increase at doses at or above 100 mg, so early attention to the 120 mg MED benchmark dose is worthwhile.
- Safety and effectiveness of opioid therapy for chronic non-cancer pain should be routinely evaluated by the prescriber.
- Assessing the effectiveness of opioid treatment should entail tracking and documenting both functional improvement and pain relief.
- If there is evidence of frequent adverse effects or lack of response to an opioid trial, a specialty consultation should be considered. Follow the guidance for seeking consultative assistance as described in the Table below.

### Table: Guidance for Seeking Consultative Assistance

<table>
<thead>
<tr>
<th>Prescribing opioid doses up to 120 mg morphine equivalent dose (MED)/day:</th>
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<tbody>
<tr>
<td>(Cumulative daily dose when using one or more opioids. See Table 4 in Appendix A of the original guideline document for specific opioid thresholds.)</td>
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</table>

- No assistance from a pain management consultant needed if the prescriber is documenting sustained improvement in both function and pain.
- Consider getting consultative assistance if frequent adverse effects or lack of response is evident in order to address:
  - Evidence of undiagnosed conditions
  - Presence of significant psychological condition affecting treatment
  - Potential alternative treatment to reduce or discontinue use of opioids

<table>
<thead>
<tr>
<th>Before exceeding 120 mg MED/day threshold:</th>
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<tbody>
<tr>
<td>(Cumulative daily dose when using one or more opioids. See Table 4 in Appendix A of the original guideline document for specific opioid thresholds.)</td>
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</tbody>
</table>

- No assistance from a pain management consultant needed if the prescriber is documenting sustained improvement in both function and pain.
- In general, the total daily dose of opioid should not exceed 120 mg oral MED. Risks substantially increase at doses at or above 100 mg, so early attention to this benchmark dose is worthwhile.
- Seek assistance from a pain management consultant to address:
  - Potential alternative treatment to opioids
  - Risk and benefit of a possible trial with opioid dose above 120 mg MED/day
  - Most appropriate way to document improvement in function and pain
  - Possible need for consultation from other specialists

Information on morphine equivalent dose calculation for use when patients are taking more than one opioid is provided in Figure 1 in the original guideline document. An electronic opioid dose calculator can be downloaded at [www.agencymeddirectories.wa.gov/guidelines.asp](http://www.agencymeddirectories.wa.gov/guidelines.asp).

### Before You Decide to Prescribe Opioids for Chronic Pain

Because of the potentially serious adverse long term effects of opioids, it is critical that the prescriber comprehensively assess the risks and benefits of treatment prior to deciding whether to prescribe opioids. Consider opioid therapy when:

- Other physical, behavioral and non-opioid measures have failed (e.g., physical therapy, cognitive behavioral therapy, nonsteroidal anti-inflammatory drugs [NSAIDs], antidepressants, antiepileptics), and
- The patient has demonstrated sustained improvement in function and pain levels in previous opioid trial, and
- The patient has no relative contraindication to the use of opioids (e.g., current or past alcohol or other substance abuse, including nicotine).

Chronic opioid therapy (e.g., more than 90 days of therapy) should only be initiated on the basis of an explicit decision and agreement between prescriber and patient. The patient needs to be informed of the benefits and risks of opioid therapy of indefinite duration. Sample agreements for the prescriber and patient can be found in Appendix G of the original guideline.

Screening for potential comorbidities and risk factors is crucial so that anticipated risk can be monitored accordingly. Depression and anxiety disorders are frequently associated with the use of opioids. Current and past substance abuse disorders appear to increase the risks of chronic opioid therapy. If substantial risk is identified through screening, extreme caution should be used and a specialty consultation (e.g., addiction or mental health specialist) is strongly encouraged. In such cases, a baseline risk assessment using the following tools should be performed and documented in the record:

1. The Opioid Risk Tool (ORT) to screen for risk of opioid addiction
2. The CAGE-AID to screen for alcohol or drug problems
3. The Patient Health Questionnaire (PHQ-9) to screen for depression severity
4. A baseline urine drug test (UDT)
5. A baseline assessment of function and pain with the 2 Item Graded Chronic Pain Scale (see Figure 2 and Appendix C in the original guideline document)

See section Screening and Monitoring Your Patient and Appendix B in the original guideline document for more details and samples of these screening forms.
After You Decide with the Patient to Prescribe Chronic Opioid Therapy

When instituting chronic opioid therapy, both prescriber and patient should discuss and agree on all of the following:

- Risks and benefits of opioid therapy supported by an opioid agreement (sample agreements can be found in Appendix G of the original guideline document)
- Treatment goals, which must include improvements in both function and pain while monitoring for and minimizing adverse effects
- Expectation for routine urine drug testing
- A follow-up plan with specific time intervals to monitor treatment

Once a decision is made to institute chronic opioid therapy, the prescriber is responsible for routinely monitoring the safety and effectiveness (improved function and pain) of ongoing treatment.

Principles for Safely Prescribing Chronic Opioid Therapy

- Single prescriber
- Single pharmacy
- Patient and prescriber sign opioid agreement
- Lowest possible effective dose should be used
- Be cautious when using opioids with conditions that may potentiate opioid adverse effects (including chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF], sleep apnea, history of alcohol or substance abuse, elderly, or history of renal or hepatic dysfunction).
- Do not combine opioids with sedative-hypnotics, benzodiazepines or barbiturates for chronic non-cancer pain unless there is a specific medical and/or psychiatric indication for the combination and increased monitoring is initiated (see Urine Drug Testing section below)
- Routinely assess function and pain status (see Tools for Assessing Function and Pain section in the original guideline document).
- Monitor for medication misuse (for a list of drug-seeking behaviors, see Reasons to Discontinue Opioids or Refer for Addiction Management section below).
- Random urine drug testing to objectively assure compliance (see Urine Drug Testing section below and detailed guidance in Appendix D in the original guideline document).

See the original guideline document for information on tools for screening and monitoring patients, as well as tools for assessing function and pain.

Assessing Effects of Chronic Opioid Therapy

Chronic opioid therapy is associated with the development of tolerance to its analgesic effects. Evidence is accumulating that opioid treatment may also paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve function and pain control.

The prescriber should assess the risks and benefits of their patient’s current opioid therapy. This assessment should include:

- Function and pain status (see Tools for Assessing Function and Pain in the original guideline document)
- Possible adverse effects of current opioid doses
- Potential psychiatric disorders affecting treatment
- Possible drug combinations or conditions that may potentiate opioid adverse effects (such as COPD, CHF, sleep apnea, current or past alcohol or substance abuse, advanced age, or history of renal or hepatic dysfunction)
- Any relative contraindication to the use of opioids (active alcohol or other substance abuse, including nicotine [see Urine Drug Testing section below])

If function and pain do not improve after a sufficient opioid trial, consider discontinuing opioids (see Tapering or Discontinuing Opioids section below). When there is evidence of significant adverse effects from opioid therapy, the provider should reduce the opioid dose and reassess the patient’s status.

Otherwise, if no reasons for dose reduction or discontinuation are identified, and the prescriber feels (with support of validated measures of function and pain) that the patient is benefiting from current therapy, continuation can be appropriate. Ongoing therapy, however, entails ongoing assessment. The screening described above should be done on a regular basis to assess progression of therapy as the patient’s condition changes over time.

Urine Drug Testing (UDT)

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse, and verify compliance with treatment. When used with an appropriate level of understanding, UDT can improve the prescriber’s ability to safely and appropriately manage opioid therapy (see Appendix D – Using Urine Drug Testing to Monitor Opioid Therapy for Chronic Non-cancer Pain in the original guideline document).

Urine drug testing is an important part of the baseline risk assessment which prescribers should perform on all candidates for chronic opioid therapy (see section Before You Decide to Prescribe Opioids for Chronic Pain above). This baseline UDT should be performed on all transferring patients who are already using opioids and for those patients who you are considering for chronic opioid therapy (e.g., 3rd opioid prescription or >6 weeks after an acute injury). Prior to testing, the prescriber should inform the patient of the reason for testing, the expectation of random repeat testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify drug testing for the individual circumstances and more accurately interpret the results.

After opioid therapy has been initiated, the prescriber should randomly repeat testing at the approximate frequency determined by the patient’s risk category based on the ORT or similar screening tools (see Table below).

Table: Recommended Frequency of UDT
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<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Recommended UDT Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk by ORT</td>
<td>Periodic (e.g., up to 1/year)</td>
</tr>
<tr>
<td>Moderate Risk by ORT</td>
<td>Regular (e.g., up to 2/year)</td>
</tr>
<tr>
<td>High Risk by ORT or opioid doses &gt;120 mg MED/day</td>
<td>Frequent (e.g., up to 3-4/year)</td>
</tr>
<tr>
<td>Aberrant Behavior (lost prescriptions, multiple requests for early refill, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)</td>
<td>At time of visit (Address aberrant behaviors in person, not by telephone)</td>
</tr>
</tbody>
</table>

MED, morphine equivalent dose; ORT, Opioid Risk Tool; UDT, urine drug testing

Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. Information from third parties, such as family and friends, can be helpful in evaluating behavior. Opioid prescribing should be avoided in patients with active alcohol or other substance abuse. Extreme caution should be used, and a consultation with an addiction specialist is strongly encouraged, prior to prescribing opioids for patients with a history of alcohol or other substance abuse.

Methods of Testing

There is no standard UDT that is suitable for all purposes and settings. Currently, two main types of UDT are available:

- Immunoassay drug testing (Initial drug test or screen) – based in a lab or office (point-of-care).
- High performance chromatography/mass spectrometry (confirmatory drug test) – available only through a laboratory

See the original guideline document for more information on these two types of UDT.

Drugs or Drug Classes to Test

The National Institute on Drug Abuse (NIDA) 5 was established for workplace drug testing and is federally regulated. However, it does not test for many commonly prescribed or abused drugs such as benzodiazepines and semi-synthetic or synthetic opioids, which may be important in compliance testing. Thus, it may be more useful to order an expanded urine drug panel to include any of the drugs listed below in addition to drugs you are prescribing:

- Cannabinoids
- Cocaine
- Amphetamines
- Opiates
- Benzodiazepines
- Alcohol
- Barbiturates
- Oxydode
- Methadone
- Fentanyl

Interpreting Results

Interpreting UDT results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. When the immunoassay result is unexpected and the patient does not acknowledge or credibly explain the result, a confirmatory test using either gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) should be ordered.

If the patient tested negative for prescribed opioids and if confirmatory testing substantiates a "red flag" result (see Table 3 in the original guideline document for "red flag" results), the prescriber should consider a controlled taper or stop prescribing opioids immediately. Prescriber may also consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

Contact your local laboratory director, toxicologist or certified Medical Review Officer (MRO) for questions about drug testing or results. To locate a MRO in your area, submit a search at the following Web site: http://www.aamro.com/locate/ 6. If a point-of-care device is used, contact technical support from the manufacturer for questions.

Specialty Consultation

Specialty consultation is recommended for ongoing severe pain symptoms with no significant improvement in function despite treatment with opioids. Consultation should address possible undiagnosed conditions, psychological conditions affecting treatment, and alternative treatments. The type of consultation obtained should be determined by the patient’s presenting signs and symptoms and history. Consultation may be with, but not limited to, a physician specializing in psychiatry, neurology, anesthesiology, pain, physical medicine and rehabilitation, orthopedics, addiction medicine, rheumatology, or oncology.

Unrecognized Diagnoses

In cases of severe ongoing pain symptoms with no improvement in function despite treatment with opioids, it is recommended you seek consultative assistance to address possible undiagnosed conditions. Examples include psychiatry, neurology, internal medicine, physical medicine and rehabilitation, orthopedics, addiction medicine, rheumatology, or oncology.

Psychological and Addiction Issues

Opioid treatment can be challenging in patients with symptoms suggestive of mood, anxiety, and psychotic disorders. Consider psychiatric and/or psychological consultation for intervention if a psychological condition is affecting treatment.

Patients with signs of alcohol or other substance abuse should be referred to an addiction specialist (see Referrals for Addiction Services).
Opioid Management

Consultative assistance for opioid management and prudent prescribing of opioids should be with a pain management expert who is familiar with and endorses this guideline. Examples of when to seek assistance include:

- Patients on >120 mg MED/day
- Questions about methadone treatment
- Tapering patients off opioids
- Aberrant behavior

Although pain may be relieved at oral morphine doses up to 120 mg MED/day, pain relief is not necessarily associated with psychological or functional improvement. Because sustained functional improvement is so critical to effective opioid therapy for chronic non-cancer pain, the prescriber should ensure that the patient meets the following conditions before considering a dosage above 120 mg MED/day:

- There are no significant psychological issues or evidence of drug-seeking behaviors, AND
- The patient has demonstrated improvement in function and pain level previously at a lower dose.

If these conditions are met, the prescriber may seek a pain management consultation or case review to support possible treatment with opioid doses above 120 mg MED/day.

Consultation with a specialist does not necessitate transfer of the patient for care or on-going opioid prescribing. However, the consultant should advise the prescribing provider on a pain management plan that may include alternative treatments to reduce or discontinue use of opioids, explanation of the risks and benefits of a possible trial with opioids above 120 mg/day MED, and the need for ongoing documentation of improvement in function and pain.

Consultations do not necessarily have to be done face to face with the patient. See Appendix E in the original guideline document for alternate forms of consultative assistance.

See the original guideline document for information on how to find a pain management specialist.

Tapering or Discontinuing Opioids

Not all patients benefit from opioids, and a prescriber frequently faces the challenge of reducing the opioid dose or discontinuing the opioid altogether. From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
- Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1 mg/24 hours (Catapres TTS-1™) weekly during the taper while monitoring for significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued. Rapid recrudescence of tolerance can occur for months to years after prior chronic use.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

An Opioid Taper Plan Calculator is available in Appendix H, Additional Resources to Streamline Clinical Care, in the original guideline document.

Recognizing and Managing Behavioral Issues during Opioid Tapering

Opioid tapers can be done safely and do not pose significant health risks to the patient. Special care needs to be taken by the prescriber to preserve the therapeutic relationship at this time. Otherwise, taper can precipitate doctor-shopping, illicit drug use, or other behaviors that pose a risk to patient safety. Extremely challenging behavioral issues may emerge during an opioid taper.

Behavioral challenges frequently arise when a prescriber is tapering the opioid dose and a patient places great value on the opioid he/she is receiving. In this setting, some patients may feel overwhelmed or desperate and will try to convince the prescriber to abandon the opioid taper.

Challenges may include:

- Focus on right to pain relief ("You don't believe I have real pain")
- Arguments about poor quality of pain care with threats to complain to administrators or licensing boards
- Attributing one's deteriorating psychological state, including suicidal thoughts, to opioid withdrawal

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary (see After You Decide with the Patient to Prescribe Chronic Opioid Therapy section above). Serious suicidal ideation (with plan or intent) should prompt urgent psychiatric consultation.

Guidelines for Optimizing Treatment When Opioid Doses Are Greater Than 120 mg MED/Day

Assessing Effects of Opioid Doses Greater Than 120 mg MED/Day

Ongoing opioid treatment requires ongoing assessment to optimize therapy. This is important in light of the evidence that not all patients receive pain relief from opioids and some develop hyperalgesia and other abnormal pain sensitivity.
that not all patients receive pain relief from opioids and some develop hyperalgesia and other abnormal pain sensitivity with chronic high dose opioid therapy. If, after using the guidelines under Assessing Effects of Chronic Opioid Therapy section above, the prescriber feels that current treatment is not benefiting the patient, a dose reduction or discontinuation is warranted. However, if current treatment is benefiting the patient as demonstrated by objective measures of function and pain, it may be appropriate to continue, while establishing a plan to monitor therapy as the patient's condition changes over time (see Principles for Safely Prescribing Chronic Opioid Therapy section above).

**How to Discontinue Opioids or Reduce and Reassess at Lower Doses**

The prescriber should assess the patient's status periodically during the tapering process. If the chosen assessment tool indicates improved patient status other than subjective pain complaints, or if there is improvement in opioid-related side effects, maintain the patient off opioids or at the new reduced dose and reassess at a later time.

Conversely, if there is evidence of functional and symptomatic deterioration following opioid taper, the prescriber may consider consulting with a pain management specialist to evaluate additional therapeutic options.

**Referrals to Pain Centers**

A referral for counseling or other support during opioid taper or dose reduction is recommended if there are significant behavioral issues. In addition, a multidisciplinary pain program may be considered when appropriate to address the psychosocial and cognitive aspects of chronic pain together with patients' physical rehabilitation. Early consultative support may prevent pain from becoming a chronic disabling condition.

**Recognizing Aberrant Behaviors during Opioid Treatment**

Patients who exhibit aberrant behaviors may or may not be at risk for opioid abuse. There is no universally accepted screening tool to predict aberrant behaviors with opioid treatment for chronic pain. However, it is important to identify aberrant behaviors as they can affect the medical management of your patients and help predict misuse of opioids (see Reasons to Discontinue Opioids or Refer for Addiction Management section below).

Patients with a co-morbid psychiatric condition or addiction are at higher risk of opioid misuse despite their attempts to follow the treatment plan. Prescribers should intensify monitoring and scrutiny and seek a consultation with an addiction specialist if there is past or active substance dependence or abuse.

**Reasons to Discontinue Opioids or Refer for Addiction Management**

- No improvement in function and pain
- Opioid therapy produces significant adverse effects
- Patient exhibits drug-seeking behaviors or diversion such as:
  - Selling prescription drugs
  - Forging prescriptions
  - Stealing or borrowing drugs
  - Frequently losing prescriptions
  - Aggressive demand for opioids
  - Injecting oral/topical opioids
  - Unsanctioned use of opioids
  - Unsanctioned dose escalation
  - Concurrent use of illicit drugs
  - Failing a drug screen
  - Getting opioids from multiple prescribers
  - Recurring emergency department visits for chronic pain management (see section on Emergency Department Guidelines in Appendix I in the original guideline document).

**Referrals for Addiction Management**

A patient who exhibits overt signs of alcohol or substance use disorder should be referred to an addiction specialist for appropriate treatment. Prognosis is poor for patients with a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis of opioid dependence or opioid abuse who do not receive treatment.

**Clinical Algorithm(s)**

An algorithm is provided in Appendix D of the original guideline document for Urine Drug Testing (UDT) for Monitoring Opioid Treatment in Chronic Non-cancer Pain.

**Evidence Supporting the Recommendations**

**Type of Evidence Supporting the Recommendations**

The type of supporting evidence is not specifically stated for each recommendation. In general, the recommendations were based primarily on a comprehensive review of peer reviewed published scientific literature. In cases where the data did not appear conclusive, recommendations were based on the consensus opinion of the committee.

**Benefits/Harms of Implementing the Guideline Recommendations**

**Potential Benefits**

- Improved pain relief
- Reduced opioid-related side effects
- Improved quality of life

**Potential Harms**

- Risk of inadequate pain control
- Risk of opioid misuse or abuse

**Summary of Key Points**

- Not all patients receive pain relief from opioids and some develop hyperalgesia and other abnormal pain sensitivity.
- The prescriber should assess the patient's status periodically during the tapering process.
- If improvement is noted, maintain the patient off opioids or at the new reduced dose and reassess at a later time.
- If deterioration occurs, consider consulting with a pain management specialist.
- Early consultative support may prevent pain from becoming a chronic disabling condition.
- Aberrant behaviors during opioid treatment should be identified and addressed.
- Patients with a co-morbid psychiatric condition or addiction are at higher risk of opioid misuse.
- Referrals to pain centers are recommended for patients with significant behavioral issues.
- Opioids should be discontinued if there is no improvement in function and pain or if the patient exhibits drug-seeking behaviors.
- An algorithm is provided for Urine Drug Testing (UDT) for Monitoring Opioid Treatment in Chronic Non-cancer Pain.
Appropriate prescribing of opioids in a safe and effective manner, including:

- Effective opioid therapy that improves function while relieving pain
- Awareness of the risks and possible ineffectiveness of high doses
- Strategies to wean patients from unsafe doses of opioids
- Strategies to support patients through the process
- Reduction in morbidity and mortality related to the use of opioids

**Potential Harms**

**Adverse Effects of Opioids**

- Recent studies indicate a dramatic increase in accidental deaths associated with the use of prescription opioids since 1999. Between 1999 and 2005, people aged 35 to 54 years had higher poisoning death rates involving opioid analgesics than those in any other age group.
- The risks of opioid use are not exclusive to the adult population. According to the Healthy Youth Survey 2008 (available at [http://www.doh.wa.gov/HealthyYouth](http://www.doh.wa.gov/HealthyYouth)), Washington teens are using prescription opioid pain medicine to get high.
- Caution should be exercised when using opioids with conditions that may potentiate opioid adverse effects (including chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF], sleep apnea, current or past alcohol or substance abuse, elderly, or history of renal or hepatic dysfunction).
- Chronic opioid therapy is associated with the development of tolerance to its analgesic effects. Evidence is accumulating that opioid treatment may also paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia.
- Opioid abstinence syndrome includes nausea, diarrhea, muscle pain and myoclonus.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued.

Refer to Appendix A in the original guideline document for considerations (precautions) for specific opioid medications.

**Contraindications**

**Contraindications**

- Current or past alcohol or other substance abuse, including nicotine, is a relative contraindication to the use of opioids.

**Qualifying Statements**

**Qualifying Statements**

These guidelines are intended as an educational aid for primary care and specialty providers who prescribe opiates for state agency clients experiencing chronic non-cancer pain. The guidelines were not developed as a disciplinary tool. The original guideline, published in 2007, was evaluated in 2009. This revised version updates the relevant data and responds to the feedback received from the evaluation.

**Implementation of the Guideline**

**Description of Implementation Strategy**

This guideline has been published on the [Agency Medical Directors' Group Web site](http://agencymedicaldirectorsgroup.org).

This guideline will be:

- Presented at professional association meetings and conferences
- Shared with other state agencies who work on preventing morbidity and mortality from opioid use
- Shared with the WA State Department of Health as they develop guidance on use of opioids in the WA administrative code

Continuing medical education will also be provided for the new guideline (see the "Availability of Companion Documents" field).

**Implementation Tools**

- Chart Documentation/Checklists/Forms
- Clinical Algorithm
- Resources
- Staff Training/Competency Material

For information about availability, see the [Availability of Companion Documents and Patient Resources fields below](http://agencymedicaldirectorsgroup.org).

Institute of Medicine (IOM) National Healthcare Quality Report Categories
Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need
- Living with Illness
- Staying Healthy

IOM Domain
- Effectiveness
- Patient-centeredness
- Safety

Identifying Information and Availability

Bibliographic Source(s)

Adaptation
Not applicable: The guideline was not adapted from another source.

Date Released
2007 Mar (revised 2010 Jun)

Guideline Developer(s)
Washington State Agency Medical Directors' Group - Independent Expert Panel

Guideline Comment
The Washington State Agency Medical Directors Group is comprised of the medical directors and health care administrators of six state agencies: Corrections, Health, Labor & Industries, Health Care Authority, Social and Health Services, and Veterans Affairs.

Source(s) of Funding
Washington State Department of Labor and Industries (L&I)

Guideline Committee
Washington State Agency Medical Directors Group's Opioid Advisory Panel

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This is the current release of the guideline.
Guideline Availability

Electronic copies: Available from the Washington State Agency Medical Directors' Group Web site.

Availability of Companion Documents

The following are available:


In addition, the following tools are available in the appendices of the original guideline document:

- Opioid Risk Tool
- CAGE-AID Questionnaire
- Patient Health Questionnaire (PHQ-9) Symptom Checklist
- PHQ-Scoring Tally Sheet
- How to Score PHQ-9
- Alcohol Use Disorders Identification Test (AUDIT) Questionnaire: Screen for Alcohol Misuse
- Center for Epidemiologic Studies Depression Scale (CES-D)
- DASA Target Data Elements Gain Short Screening Setup
- Sample Doctor-Patient Agreements for Chronic Opioid Use

Patient Resources

None available

NGC Status

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