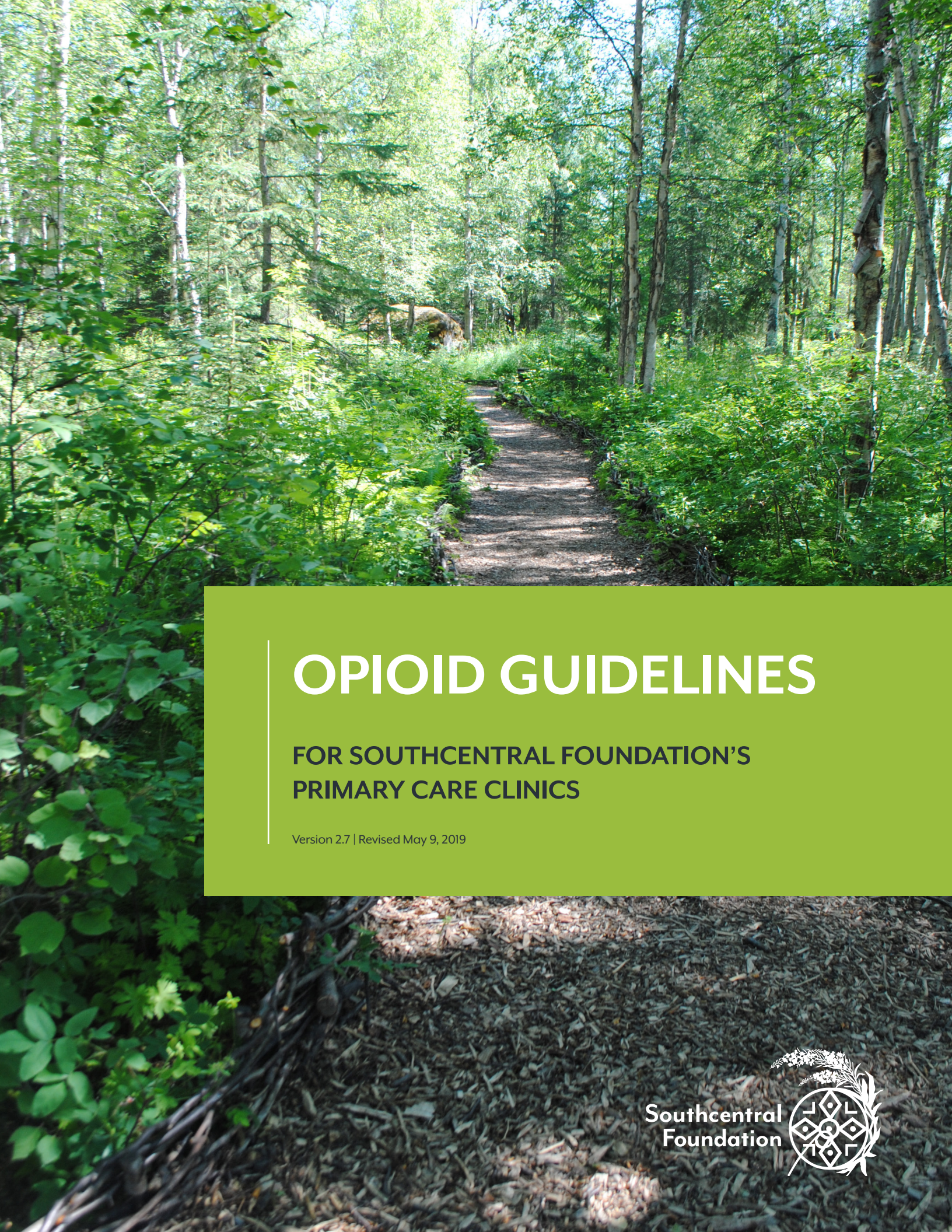

OPIOID GUIDELINES

FOR SOUTHCENTRAL FOUNDATION'S PRIMARY CARE CLINICS

Version 2.7 | Revised May 9, 2019

Southcentral Foundation

These guidelines are designed by providers, for providers to use as a standard of care for customer-owners (C-Os) affected by pain. It is estimated that approximately 10% of empaneled C-Os experience chronic pain. Working with C-Os who experience pain is stressful for the C-O, the provider, and the integrated care team. Insufficient training and support, the over-prescription of opioids, and the limited options for healthy therapeutic services contribute to the stress of every one involved. These guidelines are the standard that we expect Primary Care provider teams to adhere to.

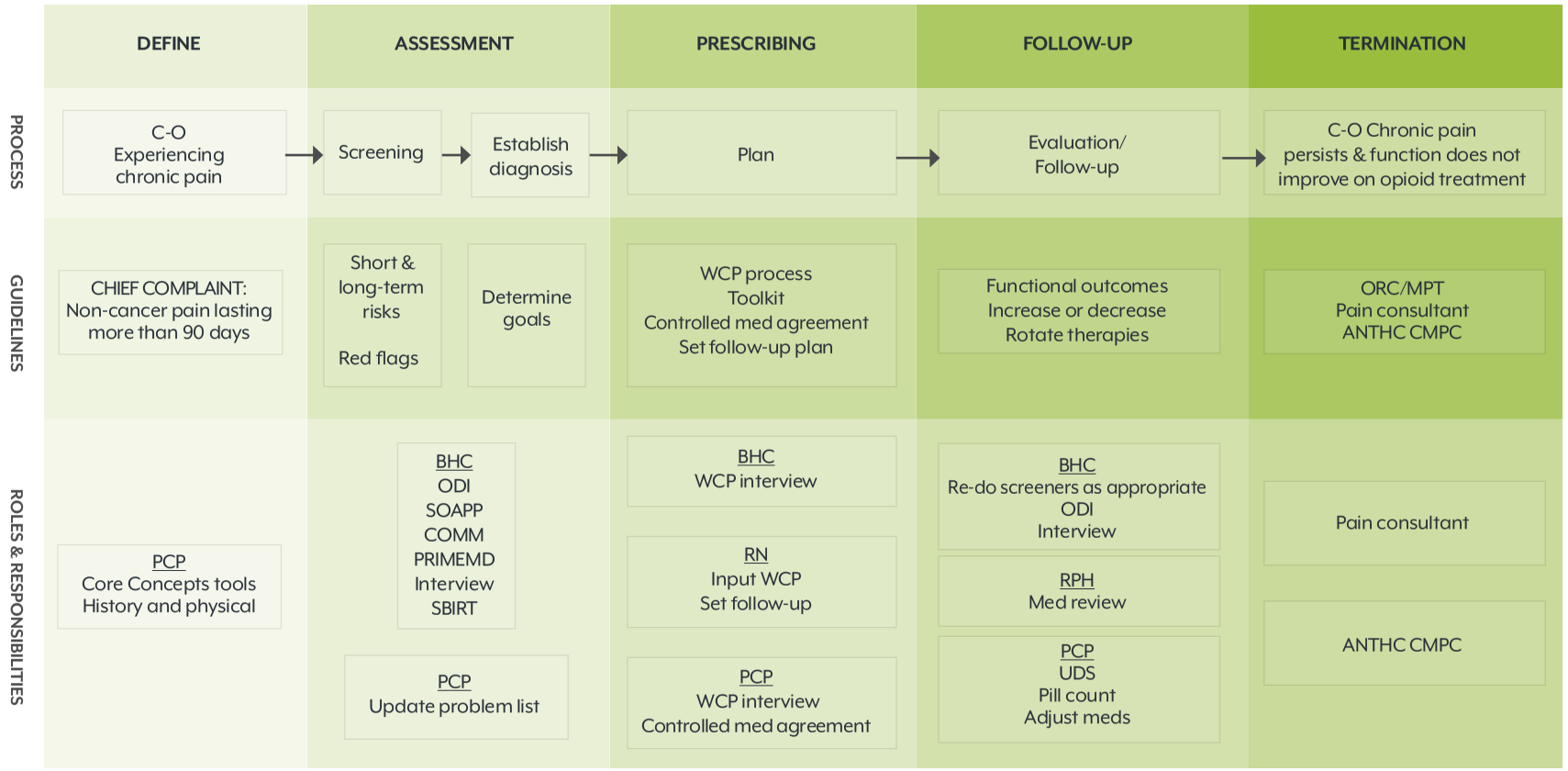

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TABLE OF CONTENTS

OPIOID PHARMACOTHERAPY FOR CHRONIC (>90 DAYS), NON-CANCER PAIN

PAIN

An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

WHAT IS CHRONIC PAIN?

Chronic Pain is pain that continues or recurs over a prolonged period (more than 90 days) caused by various diseases or abnormal conditions. Chronic pain may be less intense than acute pain. The person with chronic pain does not usually display increased pulse and rapid respiration because these autonomic reactions to pain cannot be sustained for long periods. Some factors that can complicate the treatment of persons with chronic pain are scarring, continuing psychological stress, and medication.

THE DIFFERENCE BETWEEN CANCER, ACUTE AND CHRONIC NON-CANCER PAIN:

Treatment for cancer pain and chronic non-cancer pain is different. The best indications for opioid therapy are cancer-related pain and recovery from physical trauma or surgery—the latter two indications typically involving short-term or limited term treatment. However, for non-cancer pain the goal of treatment in this setting is to provide a state of physical ease and reasonable relief from pain that will improve function and quality of life. Opioids are not always indicated and when they are, their use is limited by risk of harm. This guideline will clarify when opioids are indicated, how much is too much, and what harms can come from short and long-term use.

SIGNIFICANCE OF 90 DAY INFLECTION POINT:

Studies show that after 90 days of continuous use of opioids, opioid treatment is more likely to become life-long (>60% will need opioids for years). Additionally, studies show that persons who continue opioids for more than 90 days tend to be high risk for overdose and misuse.

ASSESSMENT

CONDITIONS THAT OPIOIDS MIGHT BENEFIT:

The available evidence suggests that opioids, when used broadly for the treatment of chronic painful conditions, provide minimal to modest pain relief without apparent improvements in functional status. Opioid treatment needs to be **individualized** with close follow-up of the desired outcomes. It may be reasonable to use opioids for those with:

- Severe pain from clear, anatomic pathology that results in functional impairment
- Short-term or limited-term post-traumatic or post-surgical pain
    - This generally includes pain from **musculoskeletal** or some **neuropathic** origins

Our primary approach to reducing pain and improving function should be educating and engaging the Customer-Owner in a multidisciplinary approach which includes:

- The primary care provider (PCP) team, and the additional ICT members, such as the Behavioral Health Consultant and Integrated Pharmacist as appropriate for disease and condition management
- Pain Consultant Physical Medicine and Rehabilitation (PM&R) and Physical Therapist Pain Consultant (PTPC) for early and advanced physical pain assessment and treatment recommendations
- Behavioral Pain Consultant (BPC) for assessment and therapies to develop readiness and engagement for those in advanced stages of persistent pain
- Complementary Medicine Clinic (CMC), Physical Therapy and Exercise (PT&E), and Traditional Healing for improved functioning
- Behavioral Health Services including Behavioral Health Consultants (BHC), Specialty Behavioral Health Services, and Psychiatric therapies for behavioral and emotional well-being
- Family Wellness Warriors Initiative for emotional and spiritual well-being
- Health Education Department (HED) and Learning Circles for wellness education, support, and quality of life

Chronic opioid therapy should only be tried as a secondary approach after non-opioid pharmaceuticals have failed to provide adequate benefits AND should only be prescribed as one modality in a comprehensive, multidisciplinary approach.

CONDITIONS THAT OPIOIDS MIGHT HARM:

Opioids often do more harm than good for some painful and disabling conditions. These conditions often have a strong mind-body component and/or have very effective disease modifying pharmaceutical treatments. Not only do opioids, as our best evidence suggests, fail to relieve chronic pain from these conditions, but they sometimes WORSEN pain over time. For those conditions being treated by disease-modifying agents, opioid therapy can make medication titrations challenging. This may be because opioids may relieve some pain and therefore decrease the perceived need to increase doses or change disease-modifying medications that may provide the greatest long-term relief.

These conditions include but are not limited to:

- Daily headaches (all kinds)
- Fibromyalgia
- Chronic, non-specific low back pain
- Chronic abdominal pain
- Rheumatoid arthritis
- Trigeminal Neuralgia
- Polymyalgia Rheumatica

SHORT AND LONG TERM RISKS:

When prescribing opioids, please discuss the risk of unintentional overdose by family members, children, friends, pets, etc., with the Customer-Owner. Medications should always be stored in a secure location.

Opioids are powerful drugs and should be reserved for intractable pain-producing disease, where the goal is comfort. Risk of overdose, overdose death and misuse are increased when:

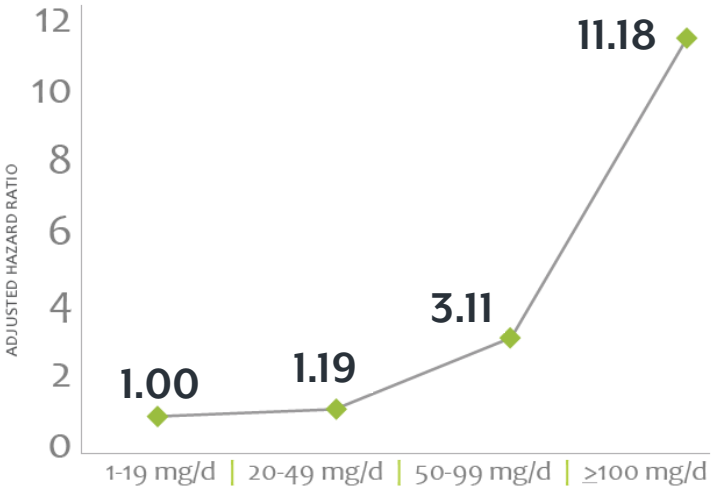
- Individual has a history of substance abuse
- There is a family history of substance abuse
- Individual has a history of childhood sexual abuse
- Individual suffers from Post Traumatic Stress (PTSD)
- Individual suffers from anxiety
- Individual suffers from depression

The following are the short and long term risks:

- Tolerance
- Substance use disorder
- Overdose
- Accidents
- Falls
- Overdose death

Hazard Ratio (HR) of overdose death, hospitalization, or respiratory failure increases substantially with opioid dose (see chart below).

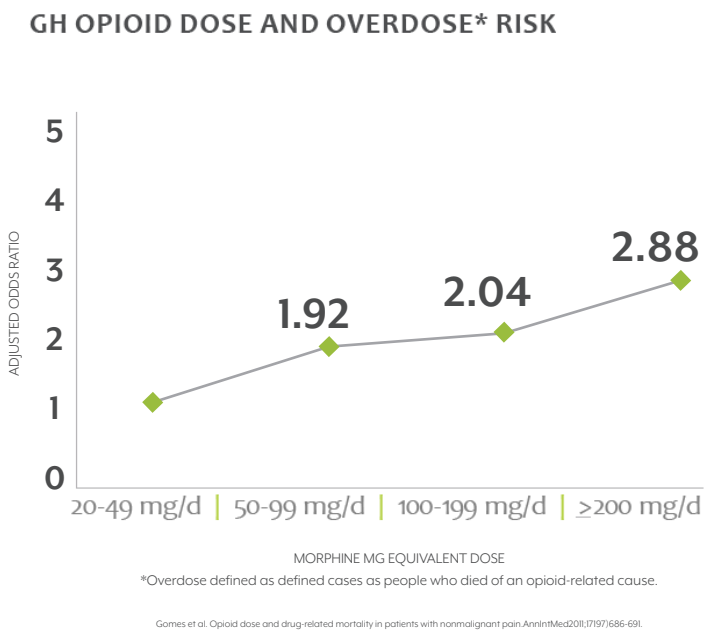
HIGH OPIOID DOSE AND OVERDOSE* RISK



*Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

Dunn et al. Opioid prescriptions or chronic pain and overdose. AnnIntMed2010;152:85-92

Odds Ratio (OR) of death also increases substantially with opioid dose (see chart below).



ADVERSE EFFECTS OF CHRONIC OPIOID USE

Using opioids for acute conditions are associated with many well-characterized side effects, including mental status changes, itching, urinary retention, constipation, respiratory depression, and hypotension. These often lessen or resolve with chronic use except for **constipation and respiratory depression**. However, there are many possible adverse effects that only seem to occur with chronic opioid use. Chronic adverse effects may be more difficult to diagnose given that they may be non-specific, can occur at any point in the treatment course, and sometimes can't be objectively diagnosed.

GASTROINTESTINAL

Constipation (30–40%). Perhaps the most common and disabling side effect of opioid therapy. Stimulation of opioid receptors slows intestinal transit time, which can be a significant issue for elderly patients. It is not unheard of for patients to be hospitalized specifically for opioid-induced constipation or an ileus. Bisacodyl (an SCF formulary option) should be considered a first-line therapy given that it addresses the underlying issue by enhancing intestinal motility, though stool softeners and laxatives may also be effective. In addition to constipation, one might experience **abdominal cramping, bloating, and nausea.** Those with gastrointestinal complaints related to opioid use have higher emergency room visits, longer hospital stays, lower quality of life, and more primary care visits.

Gastrointestinal bleeding. This risk is similar to nonsteroidal anti-inflammatory (NSAID) agents, though may occur through a different mechanism

RESPIRATORY

Sleep-disordered breathing (25%). Chronic opioid use is associated with central sleep apnea, hypoxemia, carbon dioxide retention, and disordered breathing patterns.

Respiratory depression. Tolerance to analgesia does NOT parallel tolerance to the respiratory effects of opioids. Rather, opioid doses relate linearly to risks in life-threatening respiratory depression. This risk increases with concomitant use of benzodiazepines.

CARDIOVASCULAR

Cardiovascular events (i.e. myocardial infarction, stroke). As compared to NSAIDs (all kinds), opioids are associated with a 77% higher risk of cardiovascular events, and this risk seems to be particularly high for chronic codeine use. Opioids should not be assumed to be safer than NSAIDs in terms of leading to more cardiovascular events. Hypotension has also been associated with opioid use.

NEUROLOGICAL

CNS depression (15%). Dizziness and sedation are the most common CNS effects which can lead to falls and fractures, especially in older individuals. In fact, fracture rates are double in those over the age of 65 on more than 50 mg morphine equivalents per day. One must be careful in limiting other CNS depressants, including alcohol, benzodiazepines, and barbiturates. 25 percent also have disturbed sleep.

Opioid-induced hyperalgesia (unknown prevalence). Some individuals report decreased tolerance to painful stimuli when starting chronic opioids. Exact mechanisms and the prevalence remain unclear. This adverse effect should improve with dose reductions of up to 50%.

Opioid-induced depression (30-40%). Depression rates are nearly 40% higher in chronic opioid users, and this is thought to be a cause-and-effect relationship.

ENDOCRINE

Low estrogen/testosterone (25-75%). Opioids affect every hormone from the anterior pituitary, including sex hormones, and they also disrupt the hypothalamic-pituitary-adrenal (HPA) axis. Adverse effects can include hypogonadism, infertility, sexual dysfunction, and fatigue. Further, estrogen and testosterone exert many beneficial metabolic effects that may be disrupted, possibly leading to metabolic syndrome, bone loss, changes in menses, etc.

IMMUNOLOGIC

Immunosuppression. Specific mechanisms need further investigation, but immune cells do contain opioid receptors, and the HPA axis (see Endocrine) and immune system work in tandem. Elders on chronic opioids do show increased rates of pneumonia with the strongest associations with morphine and fentanyl.

RED FLAGS:

In order to identify red flags we must first define tolerance, dependence, substance use disorder and pseudo-addiction.

Tolerance: a decrease in pharmacologic response upon repeated or prolonged administration. It can be divided into innate and acquired tolerance.

> **Innate Tolerance:** defined by pharmacogenetic factors, e.g. it may take more or less of a dose to elicit a response based on individual metabolism.
>
> **Acquired Tolerance**: changes over repeated exposure to drug metabolism and receptors at the sight of action.

Opioids are subject to both, but acquired tolerance is due mostly to receptor modulation and neurohormonal changes. The bottom line is that over time, the dose of an opioid will have to increase to maintain a constant level of analgesia.

DOSES OVER 90 MG MORPHINE EQUIVALENT PER DAY (SEE DRUG TABLE) SHOULD BE AVOIDED AND MUST BE REVIEWED BY THE PAIN CONSULTANT PM&R

Doses of 50 mg of morphine equivalents or greater are **RED FLAGS** due to increased risk and special consideration of risk. At these doses, heightened vigilance is warranted and consultation with ICT members is expected (Pain Consultant PM&R, PTPC and BPC, BHC, Pharmacist). Doses over 90 mg morphine equivalent per day (see drug table) should be avoided if possible (see pg. 46).

A CONTROLLED MEDICATION AGREEMENT IS REQUIRED WHEN PRESCRIPTIONS EXCEED 90 DAYS IN 4 MONTHS OR > 500 PILLS PRESCRIBED IN THE PREVIOUS 6 MONTHS.

There are cases in which a PCP team has utilized the pain resources available within Primary Care, consulted with the imbedded BHC, Pharmacist and Pain Team, utilized system resources and has a C-O who is still experiencing diminished quality of life due to pain. In these situations, the case may be presented to their clinic's Medical Director for review, and the PCP team may consider the coordination of a care conference. If warranted, the PCP team will assemble a multidisciplinary team (which may include Purchased Referred Care if needed) to consider the best options for the C-O who is actively engaged in finding solutions to living well with their pain.

As opioid doses increase, so do potential adverse effects. Doses of over 50 mg of morphine equivalents require close scrutiny to ensure that benefits outweigh risks and that all appropriate non-opioid therapies and non-medical treatment modalities are being considered.
Reasons to restrict or decrease opioid doses below the 50 mg morphine equivalents include:

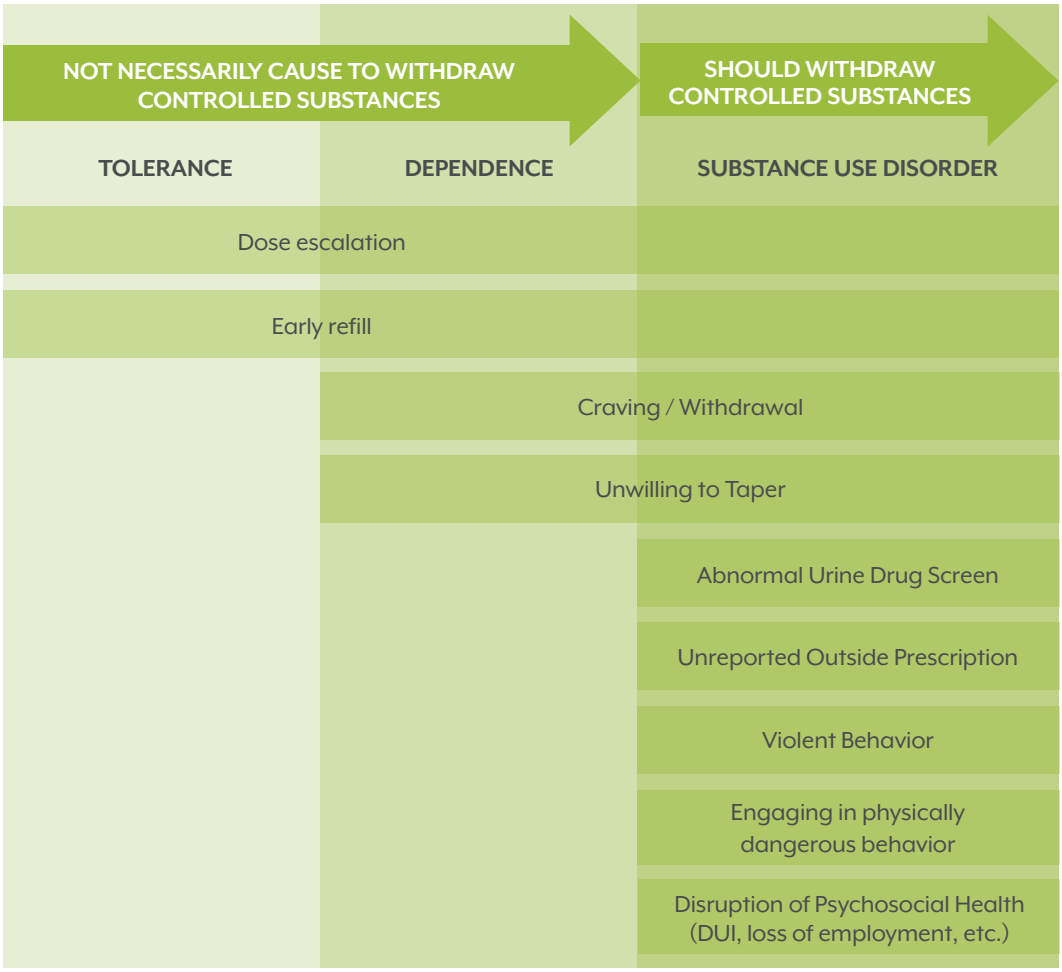
- Higher rates of overdose and death
- Greater difficulty in tapering down
- More difficulty controlling acute pain
- Higher rates of mental health and substance abuse disorders
- Higher rates of falls and fractures in the elderly
- Less likely to improve function or ability to work
- Higher rates of endocrinopathy (i.e. low libido, fertility)
- Higher rates of immune dysfunction

For more information on avoiding dose escalation due to tolerance, see **"Rotating opioid therapies"**

DEPENDENCE AND SUBSTANCE USE DISORDER/ABUSE:

Dependence can be a normal physiological response to taking a medication that can lead to craving and withdrawal. **Substance Use Disorde**r or **abuse** is typically associated with persistent seeking of drugs despite harm to oneself or another.

Each of these things can be hard to identify as they all exist within a spectrum of behavior. Use the following table to help identify these "red flags" related to opioid use.



C-Os exhibiting addictive behavior should be tapered off of opioids and perhaps other controlled medications with abuse potential (pregabalin, benzodiazepines, zolpidem). Consider Opioid Review Committee (ORC) evaluation.

*****IMPORTANT NOTE*****

Pseudo-addiction: Addiction-like behavior that results from insufficient pain control, e.g.: A C-O seeks and early refill of pain medication because they have been using slightly more than prescribed. ICT should evaluate if pain regimen is optimized (opioid and non-opioid) or if opioid tolerance is in play; or if underlying disease process has worsened or a new disease process is involved.

HOW DO I DECIDE WHEN TO START OR CONTINUE OPIOIDS?

Management of chronic pain is never simple. Opioids may be considered in managing serious pain when other therapies for chronic pain have been exhausted, **OR** to assist the C-O to successfully participate in these treatments with the intention to no longer require use of opioids after therapy has been completed (other therapy examples include: motivation, activation, self-help, counseling, physical therapy, exercise programming; non opioid analgesics such as gabapentin, duloxetine, pregabalin, as well as medication for depression/anxiety/PTSD).

Ideally, any decision to treat with medications, including opioids, should involve rational polypharmacy and tailoring the mechanism of action of medication to the type of pain (e.g. membrane stabilizing agents and SNRI's for neuropathic pain syndromes).

When a C-O who has been using opioids is transferred from another provider panel, it is the new provider's decision while working with the C-O to continue opioid therapy. Treating with opioids can be considered when there is intractable pain-producing disease and the goal is to provide a state of physical ease and reasonable relief from pain and constraint. Providers have the option of not prescribing opioids. In managing pain with chronic opioids, the provider may be expected to treat both chronic pain and opioid dependence. Please refer to **managing chronic pain and opioid dependence for further guidance.**

DETERMINING GOALS OF TREATMENT:

In addition to partnering with the C-O, the provider may use SCF measurement tools as a means of understanding the appropriate treatment, and for determining risk of opioid misuse (Prime MD, SBIRT, COMM, SOAPP-R). Goals of treatment should be assessed through the development of a Wellness Care Plan and are expected to change as progress is made or issues arise. It is important to develop a clear understanding between the provider and the C-O of risks and benefits of opioid therapy, and to use the Wellness Care Plan as a care agreement. Visits for Wellness Care Plans will take more time, at least 30–45 minutes. Use a single prescriber, and a single pharmacy, with regular pick up at the scheduled fill date. At visits pain and function should be monitored; behavioral changes (depression, anxiety) assessed; Millennium urine testing; and accessing the Alaska State Prescription Drug Monitoring Program (PDMP) is mandatory. Counseling and BHC access should continue, as well as possible referrals to Physical Therapy, Complementary Medicine, and Traditional Healing.

PRESCRIBING

WHEN PRESCRIBING CHRONIC OPIOID MEDICATION, A CUSTOMER-OWNER NEEDS TO:

1) Sign the Controlled Medication Agreement annually
2) Be on a Wellness Care Plan
3) Receive the Risk & Benefits of Opioid Medication Handout

To align the SCF Primary Care Opioid Guidelines with the State of Alaska House Bill 159 and the more recent CMS Medicare Part D - Opioid Prescribing rule change (January 2019), prescribers must adhere to the following:

- An initial opioid prescription will be limited to a 7-day supply for C-Os who have not had an opioid prescription filled within the past 60 days (opiate naive).
- Upon review of the prescription, a Pharmacist will consult with the prescriber regarding a hold when the prescription:
  - Exceeds the 7-day supply limit for initial opioid fills for opioid naïve C-Os
  - Exceeds 90 MME
  - Contains concurrent opioid and benzodiazepine use
  - Contains duplicative long-acting (LA) opioid therapy
- If the prescription is for a minor, the prescriber must discuss with the parent or guardian why the prescription is necessary and the risks associated with opioid use.
- The prescriber must document in the record the condition triggering the prescription, indicate a non-opioid alternative is not appropriate to address the condition, and, if applicable, the reason for exceeding the quantity.
- Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and C-Os being treated for active cancer-related pain are exempt from these interventions.
- This guideline is not intended to impact a C-O's access to medication-assisted treatment (MAT), such as buprenorphine.
- In the event of a conflict between the prescriber and the pharmacist, the issue shall be escalated to the pharmacist's supervisor. The supervisor will discuss unresolved issues with the prescriber's supervisor. If needed, the Chief Medical Officer or the Medical Director of Quality Assurance may be consulted for arbitration. Reference **ANMC Pharmacist Prescription/Order Verification Procedure Reference # 2008**

PHARMACOTHERAPY OPTIONS

(Schedule II (CII) in **bold** – requires hard copy prescription to pharmacy)

OPIOIDS: COMBINATION SHORT-ACTING

NAME	FORMULARY OPTIONS	50MG MORPHINE EQUIVALENT	90MG MORPHINE EQUIVALENT	NOTES
APAP/Codeine	TAB: 300/30mg; Elixir: 120/12mg/5mL;	330mg	600mg	
APAP/ Hydrocodone	TAB: 325/5mg Oral Soln: 167/2.5mg/5mL, 500/7.5mg/15mL;	50mg	90mg	
APAP/ Oxycodone	TAB: 325/5mg Oral Soln: APAP 325/5mg/5mL;	33mg	60mg	

OPIOIDS: SHORT-ACTING

NAME	FORMULARY OPTIONS	50MG MORPHINE EQUIVALENT	90MG MORPHINE EQUIVALENT	NOTES
Oxycodone	TAB: 5mg, 10mg, 15mg; Oral Soln: 5mg/5mL, 20mg/1mL	33mg	60mg	
Morphine	TAB: 15mg, 30mg Oral Soln: 10mg/5mL	50mg	90mg	
Codeine	TAB: 30mg	330mg	600mg	
Hydromorphone	TAB: 2mg, 4mg	12.5mg	22.5mg	

OPIOIDS: LONG-ACTING

NAME	FORMULARY OPTIONs	50MG MORPHINE EQUIVALENT	90MG MORPHINE EQUIVALENT	NOTES
Morphine ER	TAB: 15mg, 30mg, 100mg	50mg	90mg	
Fentanyl Patch	72hr patch (mcg/hr): 12.5mcg, 25mcg, 50mcg, 75mcg, 100mcg	*See Pharmacist, variable	*See Pharmacist, variable	Patients with fever- increased body temperature may increase release of fentanyl; monitor patients for opioid adverse effects and modify dosage as necessary
Methadone	TAB: 5mg, 10mg; Oral Soln: 5mg/5mL, 10mg/1mL, 10mg/5mL	*See Pharmacist, variable	*See Pharmacist, variable	EKG QTc monitoring recommended. QTc >490-500 msec **avoid use**. Methadone has unique risks. Not generally a 1st line option. Consult with pain specialist and/or pharmacist if you are considering use.
Oxycodone ER	TAB: 10mg, 20mg, 40mg, 80mg	40mg	80mg	
Buprenorphine Patch (non-formulary)	7-day patch (mcg/hr): 5, 10, 15, 20 mcg/hr	*See Pharmacist	* See Pharmacist	Indicated for pain. Not indicated for substance use disorder treatment.

NSAIDS

NAME	FORMULARY OPTIONS	NOTES
Ibuprofen	TAB: 400mg, 800mg, Susp: 100mg/5mL	Restricted: 100mg/mL oral susp - PEDs only, no refill
Naproxen	TAB: 250mg, 500mg, Susp: 125mg/5mL	Restricted: 125mg/5mL oral liq - PEDs special request only
Meloxicam	TAB: 7.5mg, 15mg, Oral Susp: 7.5mg/5mL	
Piroxicam	CAP: 20mg	
Nabumetone	TAB: 500mg	Recommended: chronic pain - rheumatoid/ osteoarthritis failing 2 NSAIDS
Etodolac	CAP: 300mg, TAB: 400mg, 500mg	Recommended: chronic pain; ankylosing spondylitis; failed 2 NSAIDs
Indomethacin	CAP: 25mg, 50mg; ER CAP 75mg	
Sulindac	TAB: 150mg, 200mg	Restricted: Must be initiated by Gastroenterology but can be refilled by Primary Care
Ketorolac	INJ: 30mg/mL	In-clinic use only

TOPICAL AGENTS

NAME	FORMULARY OPTIONS	NOTES
Diclofenac Topical Gel	Topical gel: 1%,	Restricted: a maximum of five tubes dispensed per month; should only be used in C-Os who fail oral NSAIDs ($$$)
Lidocaine Patches	Topical Patch: 5%	30 patch maximum per patient per month Can be cut to shape, MAX three patches on at once
CAPsaicin Topical Cream	Topical Cream: 0.075%	QID x 4 weeks for maximum effect
CAPsaicin Topical Patches	Topical Patch: 8%	Restricted to specialty pain services, in clinic use only

SKELETAL MUSCLE RELAXERS

NAME	FORMULARY OPTIONS	NOTES
Baclofen	TAB: 10mg, Oral Susp: 10mg/mL	Best for Elders (i.e. this medication is not on the BEERs list)
Cyclobenzaprine	TAB: 10mg	
Tizanidine	TAB: 4mg	Obtain LFTs at baseline and 1,3, and 6 months for chronic use. CAUTION: QTc prolongation, esp. with fluoroquinolones
Methocarbamol	TAB: 500mg, 750mg	**Not for use with opioids**

TRICYCLIC ANTIDEPRESSANTS

NAME	FORMULARY OPTIONS	NOTES
Amitriptyline	TAB: 10mg, 25mg, 50mg	Recommend ECG on all patients >50 years old before starting these medications. Risk of prolonged QT syndrome.
Nortriptyline	CAP: 10mg, 25mg, 50mg	Recommend ECG on all patients >50 years old before starting these medications. Risk of prolonged QT syndrome. Least anticholinergic, better for elders.

SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

NAME	FORMULARY OPTIONS	NOTES
Duloxetine	CAP: 20mg, 30mg, 60mg	Avoid abrupt discontinuation (withdrawal)
Venlafaxine	IR CAP: 75 mg ER CAP: 37.5mg, 75mg, 150mg	Avoid abrupt discontinuation (withdrawal) IR: BID dosing ER: Daily dosing

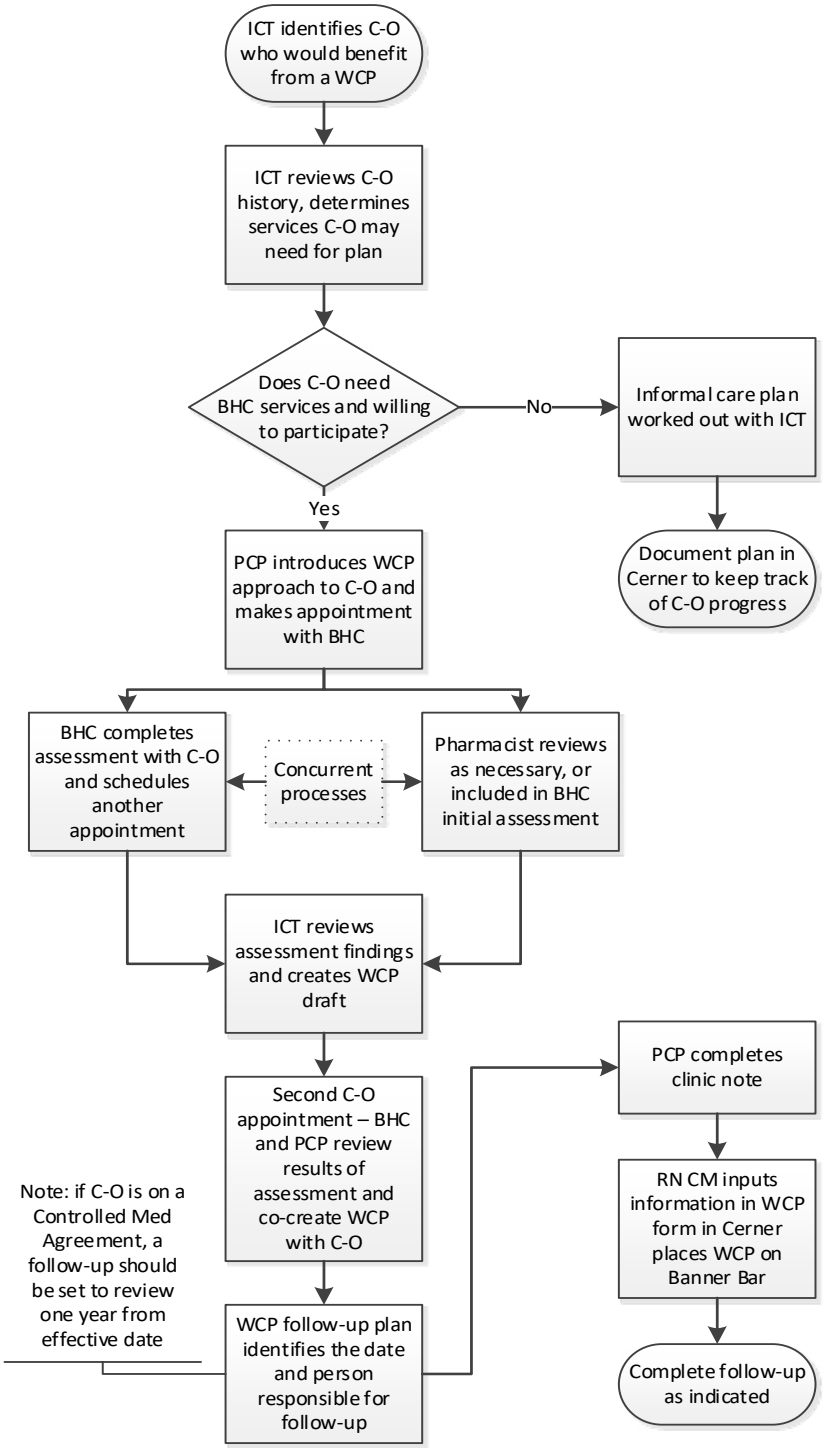
MEMBRANE STABILIZERS

NAME	FORMULARY OPTIONS	NOTES
Gabapentin	CAP: 100mg, 300mg, 400mg; Oral Soln: 250mg/5mL	Avoid abrupt discontinuation (seizure)
Pregabalin	CAP: 25mg, 50mg, 75mg, 100mg	Avoid abrupt discontinuation (seizure)

NOT FOR CHRONIC PAIN

NAME	FORMULARY OPTIONS	NOTES
Tramadol	TAB: 50mg	Tramadol is a weak opioid receptor agonist as well as active at the serotonin receptor. Potential drug interactions, likelihood of severe withdrawal symptoms, and weak analgesic potential make this a poor choice for chronic pain.
Meperidine	TAB: 50mg	Contraindicated in chronic pain due to fatal drug interactions

HOW TO START, WHO'S INVOLVED AND DELEGATING RESPONSIBILITIES USING THE WELLNESS CARE PLAN PROCESS



On the previous page is the process to begin a WCP with a C-O. There are differences between an SCF Controlled Medication Agreement (Opioid Agreement) and a WCP:

SCF CONTROLLED MEDICATION AGREEMENT: An agreement between the C-O and the provider, detailing the responsibilities of each. This agreement is to be in place as long as a C-O is being prescribed maintenance opioids, and is void if the C-O's provider changes. A Controlled Medication Agreement should be reviewed every 12 months.

WELLNESS CARE PLAN (WCP): A comprehensive care plan aimed at the overall wellness of the C-O.

A C-O must have an SCF Controlled Medication Agreement, a completed Risk and Benefits of Opioid Medication handout, and a WCP if being prescribed chronic opioid medications.

In addition to the WCP, if maintenance opiate therapy is indicated, or transferring from a provider and already on maintenance opiate therapy, the following steps need to occur:

- CMS will assist C-O in scheduling the following appointments:
  - History & Physical with PCP to review need for opiate therapy
  - Chronic Pain Assessment with BHC
    - Pharmacologic assessment/education with integrated pharmacist
- After completion of appointments, ICT will review C-Os case and determine if opiate therapy would be beneficial. If so,
  - PCP will determine appropriate dosage, starting with the lowest rational dose, refill frequency, etc.
  - ICT will develop a WCP and a Controlled Medication Agreement outlining additional treatment recommendations, refill, U-Tox schedule, etc.
  - C-O will review WCP and Controlled Medication Agreement with provider. Signed copies will go into the chart and be given to C-O
  - Responsibilities are determined by ICT and C-O and outlined in WCP
- If C-O transfers to a new PCP and is already on maintenance therapy, the new PCP has the right to adjust the medications and/or change the goals/steps outlined in the WCP in conversation with the C-O.

IF C-O PANEL TRANSFERS THE OLD CONTROLLED MEDICATION AGREEMENT IS VOID. A NEW CONTROLLED MEDICATION AGREEMENT IS SIGNED WITH THE NEW PROVIDER IF THE DECISION IS MADE TO CONTINUE OPIATE THERAPY.

PROVIDER RESPONSIBILITIES

- Introduces WCP concept to C-O
- Defines clear expectations and any clinical findings (mental, emotional, spiritual, physical)
- Co-creates plan with the C-O based on BHC information and C-O goals
- PDMP review - see PDMP review (Appendix 3)
- Reviews WCP in Cerner, adds medication plan in Cerner and approves
- Huddles regularly to review and evaluate WCPs
- Follows up on progress of plan in subsequent visits
- Review the Controlled Medication Agreement with the C-O

RN CASE MANAGER RESPONSIBILITIES

- Provides input and information during the creation of the WCP
- Enters information into the power form and adds WCP to Banner Bar
- Makes any necessary referrals
- Coordinates and ensures follow up

BEHAVIORAL HEALTH CONSULTANT RESPONSIBILITIES

- Reviews C-O information with PCP, RN CM and in medical chart
- Determines level of and type of intervention with ICT (interview, assessments, team coaching)
- Completes interview and appropriate assessment(s) as needed
- Provides recommendations and feedback to PCP/RN CM after assessment
- Assesses for differential diagnosis (substance use disorder, underlying mental health, etc)
- Co-creates WCP with C-O, PCP and RN CM
- Provides brief intervention
- Follows up with C-O and ICT as indicated

CASE MANAGER SUPPORT RESPONSIBILITIES

- Schedules WCP appointments
- Effectively manages C-O requests
- Watches the WCP Follow Up Action List to ensure Follow Ups are scheduled

INTEGRATED PHARMACIST

- Review current and proposed medications
- Work with PCP on prescribing appropriate dose, review possible interactions and side effects, and assist with opioid taper and rotation planning
- Provide education to ICT and C-O on medication management chronic pain

CONTROLLED MEDICATION AGREEMENTS AND WELLNESS CARE PLANS

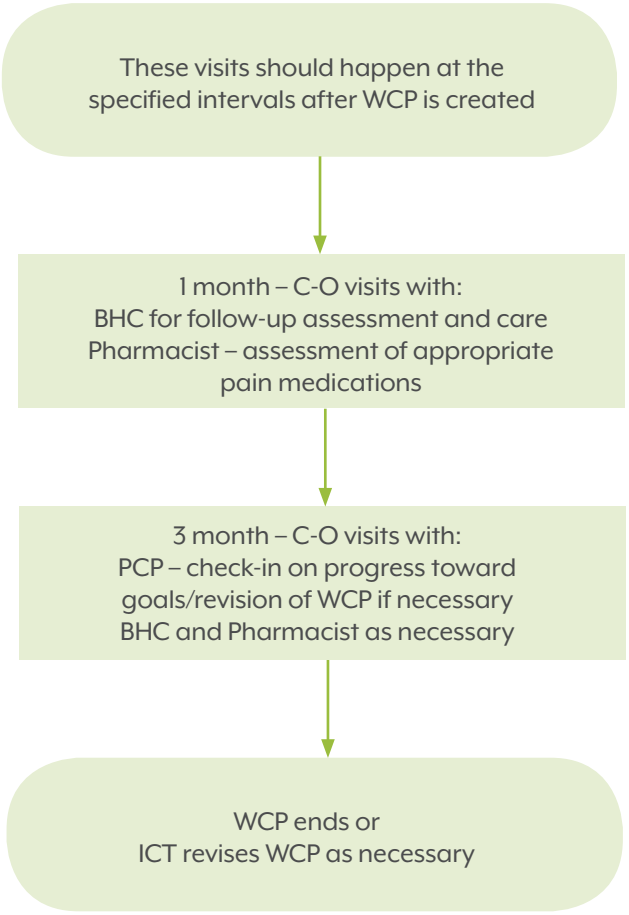
Key Elements of the SCF Controlled Medication Agreement include:

- C-O Responsibilities when taking opioid medications
  - Compliance with refills, UDS, pill counts, etc.
  - Informed consent of risk when taking medications
  - Keeping up on health maintenance appointments and follow through on scheduled appointments.
  - Awareness and agreement to consequences of non-adherence with refills, U-Tox, pill counts, DNKA's, etc.
- ICT Responsibilities when prescribing opioid medications
  - Ensure prescribing of medications is not causing harm to C-O
  - Monitor for abuse, dependence, and substance use disorder
  - Monitor for diversion of medications
  - Monitoring for compliance to SCF Controlled Medication Agreement
  - PDMP review (see appendix 3)

How Does This Relate to a Wellness Care Plan:

- When a C-O begins maintenance opioid therapy, the SCF Controlled Medication Agreement must be put in place.
- A Wellness Care Plan should be developed and clear goals established(see WCP Handbook)
    - o Examples of WCP goals if a C-O is on opioids
        - Could include follow up appointments
        - Schedule for monthly refills, U-Tox, pill counts
        - Behavioral goals to improve/enhance overall functioning
        - Regular visits to PT&E, Complementary Medicine or Wellness Center
        - A written plan that both the C-O and ICT can reference

RECOMMENDED VISIT FREQUENCY AND WHO TO SEE



*Other visits may be necessary dependent upon C-O needs.

ROUTINE ADHERENCE TO SCREENING

Recommended screenings:

Initial Screenings

- BHC Pain Assessment
- Substance Abuse Potential
- Functional Screening
- Urine Drug Test (see page 35)
- PDMP review (see appendix 3)

Follow-Up Screenings

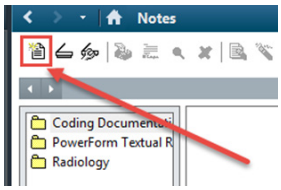
- Urine Drug Test (see page 35)
  - Low-risk: Randomly during therapy, ideally between fills, and at least every 6 months.
  - High-risk: Perhaps monthly (ICT dependent plan)
- Alaska PDMP review (see appendix 3)
- Functional Screening:
  - Up to monthly, but no longer than three months for dose adjustment/efficacy screening (see "Are they working? Harming?"), then annually thereafter (barring change in pain pathology) being the maximum time between appointments.
- Pill Count - at least twice annually randomly between prescription renewals

PRN Screenings

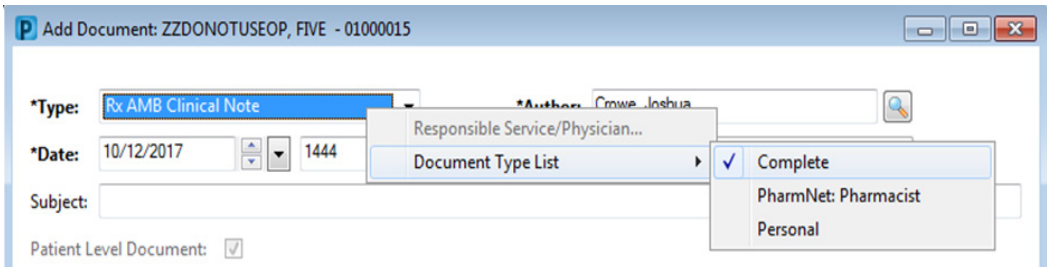
- Sleep – Often involved co-morbidity
- Depression and Anxiety
- PDMP review (see appendix 3)
- Physical assessment – PT/Comp Med

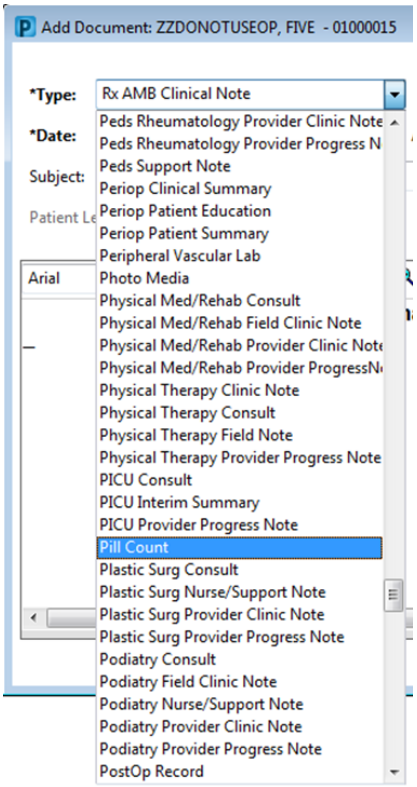
Using the Pill Count Note type

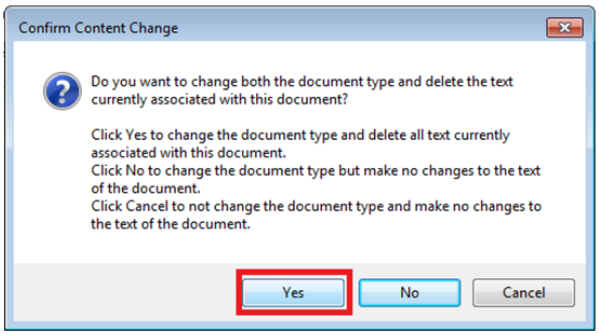
In Notes section of the customer-owner chart, click the Add icon



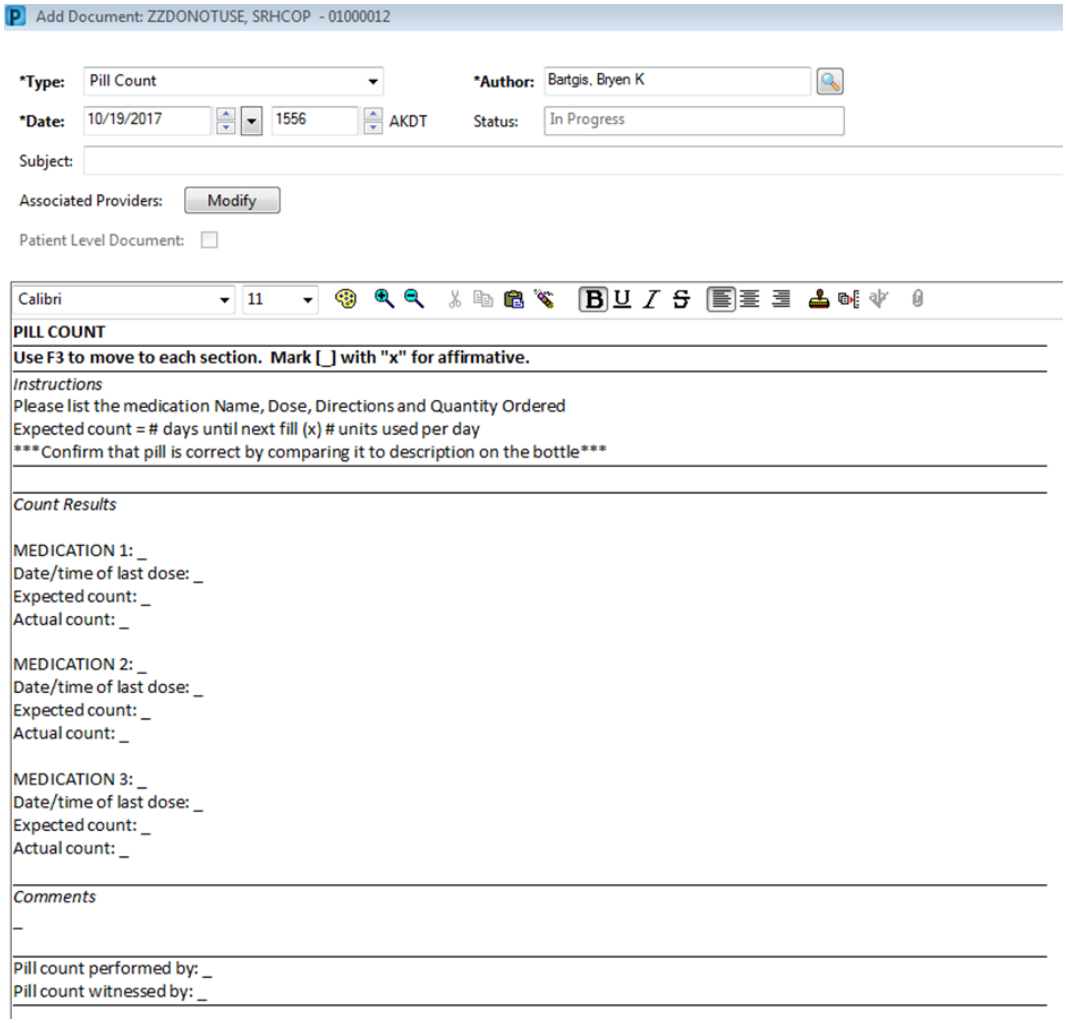
Once the Add Document window opens, **right click** on the side of Document type drop list to select the complete list of Note types







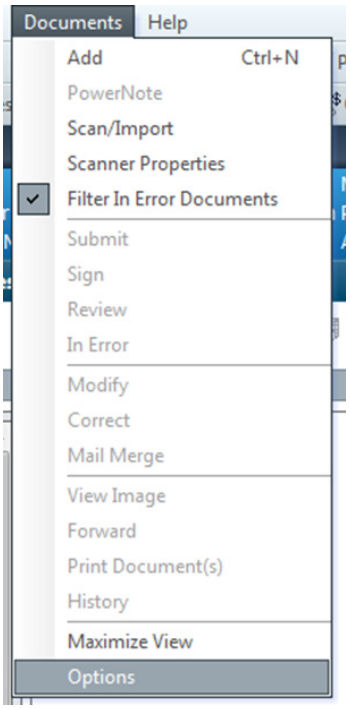
Once you select the Pill Count Note type the template will pre-populate. Use the F3 key on your keyboard to skip to the next "_".

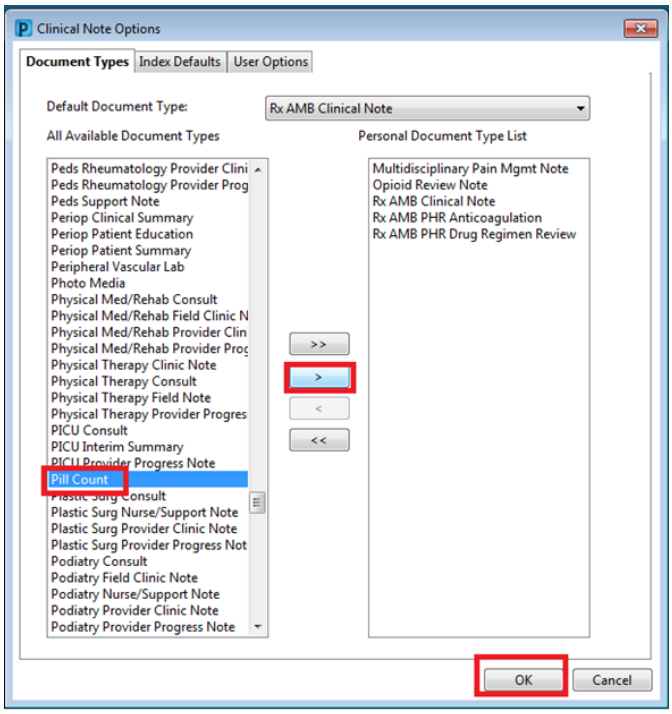


Once you have completed the form click Sign.

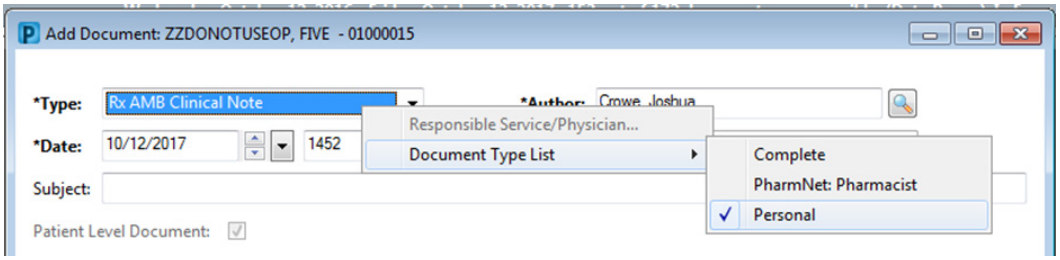
ADDING "PILL COUNT" TO YOUR DEFAULT NOTE LIST

In the "NOTES" section of Powerchart, select from the topmost menu "Documents" → "Options"





Once the Add Document window opens, **right click** on the side of Document type drop list to select your "Personal" note list



FOLLOW-UP CARE

ARE THEY WORKING? HARMING?

- Opioid therapy should only be continued, or dose increased, when there are marked functional positive outcomes.
- Marked functional positive outcomes would include, but not be limited to, the following:
  - Enhanced mobility (noted in a physical exam and self-report by C-O)
  - Increase in physical activity and exercise
  - Increase in ability to perform ADL's
  - Improved relationships with support system
  - Increase in positive activities (working, volunteering, social activities)
  - Improved overall mood functioning which can be monitored through self-report and/or decrease in scores on depression and anxiety (BHC)screenings
- If C-O is requesting increased doses of medication, PCP should use clinical judgment and other ICT members' judgment in determining if this is necessary (See **Red Flags**) and should consider:
  - Evaluation of what is not working with current dose
  - Evaluation of whether increased dose will allow C-O to achieve goals
  - Evaluation of whether increased dose will add to concerns of substance use disorder, abuse, dependence, or diversion
  - Evaluation of whether increased dose will conflict with other medications or medical diagnoses
  - If dose is increased, dose should only remain increased if functional outcomes are being achieved.
- Plan should always be developed to consider functionality without medications

WHEN SHOULD DOSE BE INCREASED?

- In conjunction with therapies that may increase pain, but have expectation of improving overall function such as surgery, PT, chiropractic, etc... Likely a temporary increase.
- Increases based on tolerance should be expected—up to a reasonable maximum, e.g. 50 mg morphine equivalent daily. Changing pain med/type of opioid could be considered (see Opioid Rotation).
- When there is acute chronic trauma and/or aggravating chronic pain issues.
- When there is a new injury and pain med adjustments (adjust dose based on level of pain and functioning).

WHEN SHOULD THE DOSE BE DECREASED?

- When there is improvement in function and/or pain level
- At the request of the C-O
- When the C-O fails to adhere to the SCF Controlled Medication Agreement
- After successful interventional pain procedure, or surgery and recovery
- When the initial dose is too strong and decrease is needed due to sedation or other side effects
- When there are adverse reactions/side effects
- When working with Integrated Pharmacists to develop Taper Plan
- When surgery is upcoming and you would like to decrease the dose pre-operatively to maximize post-operative pain treatment. A plan is made with the C-O that post-operative increase in pain medication dosing is temporary and will be decreased in a time frame concordant with surgeon's expectations.

SHORT-ACTING VS. LONG-ACTING STANDARDS OF CARE

When starting opioid therapy for chronic pain, CDC guidelines recommend prescribing immediate release opioids instead of extended release/long acting opioids, for concern for higher risk for overdose when initiating treatment with extended release/long-acting opioids (versus initiating treatment with immediate release opioids).

A C-O may be a candidate for transitioning from short-acting to long-acting if they meet the following criteria:

- C-O is on a short-acting dose sufficiently high to transition to long-acting (appox.45-60 mg morphine equivalents of short-acting)
- C-O is experiencing wearing-off effects and needs better 24 hour analgesic coverage
- Short acting opioids are causing side effects related to high-peak concentrations (mood changes, nausea, vomiting, somnolence, etc.)

A C-O may not be a candidate for transitioning from short-acting to long-acting opioids if:

- C-O is a stable on low-dose (<60 mg morphine equivalents) regimen of short-acting opioids

HELPFUL TIPS

- Be aware of **FDA guidelines** for caution in use of long acting/extended release opioids -
- Be aware of 2018 Medicare Part D changes as noted on page 15
- Long-acting opioids should be scheduled, never PRN
- When converting from a short-acting to a long-acting opioid, make sure to account for incomplete cross-tolerance
- When transitioning, only convert approximately 60% of the total daily morphine equivalents to a long-acting form, **leave the remaining approximately 40% for short-acting opioids for breakthrough pain**
- When adjusting daily dose upward, increase the long-acting preferably, not the short-acting
- Don't base long-acting conversion on documented short-acting dose. Verify **actual** stable dose (i.e. daily morphine equivalents taken over 72-120 hours)
- Always have a bowel regimen in place at the initiation of all opioid therapy

EXAMPLES:

SCENARIO 1

- C-O is currently on the following opioid regimen for pain lasting >90 days:
- APAP/hydrocodone 325/5mg, 1-2 q6h prn pain
- Interview with C-O reveals that they have been taking 1 tab BID – TID (10-15 mg morphine equivalent daily
- Conclusion: not a candidate for long-acting opioids, adjust script and quantity prescribed to match reported dosing and frequency

SCENARIO 2

- C-O on APAP/oxycodone 325/5mg 1-2 up to QID
- C-O reports taking 2 tabs QID every day (total daily oxycodone = 40mg), always feels like he is chasing his pain
- C-O qualifies for long-acting opioids (has had appropriate diagnostic evaluation, alternate treatments, non-opioid tx, and completed WCP, Controlled Medication Agreement, etc.); conversion as follows:
    - morphine: oxycodone conversion is 1:1.5, thus 40mg daily oxycodone = 60mg daily morphine equivalents
        - Reducing total daily dose by 25-50% for incomplete cross-tolerance = 20-30mg
    - 80% of that dose is 32mg morphine equivalents
    - Allowing for approx.20% of total daily dose for short-acting medications
        - Morphine ER 15 BID + APAP/oxycodone 325/5mg MAX 3/day for breakthrough pain

ROTATING OPIOID THERAPIES

Sometimes, increasing opioid doses are hindered by a lack of effectiveness or side effects. Opioid rotation (or "opioid switching") is a technique used to optimize the analgesic effects of opioids while minimizing intolerable side effects. This should be considered as an alternative to discontinuing opioid treatment altogether.

Specific indications include intolerable side effects with poor analgesia, problematic drug-drug interactions, preference for a different route of administration, change in clinical status or settings that suggest a benefit from an opioid with different pharmacokinetic properties, and financial/availability considerations.

There is insufficient evidence to support the benefit of this technique, and so no evidence-based guidelines have been developed. However, several small, low-quality trials universally support this strategy. Therefore, deciding to rotate opioid therapies should be based on shared decision-making between the provider and C-O.

WHAT IS CROSS-TOLERANCE, AND HOW SHOULD THIS BE USED WHEN DECIDING ON OPIOID DOSING?

Cross-tolerance happens when tolerance that occurs with one drug occurs with other drugs that are usually in a similar class. In the case of opioids, this cross-tolerance is only partial, or "incomplete." The success of an opioid rotation depends on determining equianalgesic doses; this depends on individual drug pharmacodynamics and individual variation. Because of incomplete cross-tolerance, doses of the new opioid should be decreased by **25 – 50%** of the calculated equianalgesic dose. In the spirit of "do no harm," aim for lower doses of the new opioid but not low enough to induce withdrawal, and then titrate upwards as indicated.

Rotation Guidelines:

1. Calculate the equianalgesic dose of the new opioid based on the table in appendix 1.
2. Decrease the dose by 40% (25 – 50%) (or by 75 – 90% if switching to methadone).
    a. Choose upper bound (50%) if elderly, mentally frail, or rotation to/from greater than 90 mg morphine equivalents
    b. Choose lower bound (25%) if C-O does not meet these criteria or if switching from the same opioid with a different route of administration
    c. The dose decrease is based on the fact that being tolerant to one opioid may make you somewhat tolerant to another at the same effective dose, but not all the way. You have to decrease the total daily morphine equivalent dose when switching to a new agent or you run the risk of OD and adverse event.
3. Follow up on functional goals as outlined elsewhere in this guideline and adjust new opioid dose as indicated.

COURSES OF ACTION WHEN FACED WITH ABNORMAL URINE DRUG SCREENS AND PILL AUDITS

URINE DRUG SCREENING (UDS) (ALSO REFERRED TO AS A URINE DRUG TEST (UDT)) ARE REQUIRED IN CHRONIC PAIN MANAGEMENT TO HELP IDENTIFY MEDICATION ABUSE, MISUSE, DIVERSION, AND USE OF ILLICIT SUBSTANCES.

As an initial qualitative test, a Point-of-Care (POC) multidrug screen should be performed. In most circumstances, qualitative UDS is sufficient to confirm both that the C-O is using prescribed medications appropriately and that no other controlled medications or illegal substances are being used. If the qualitative test reveals the need for definitive quantitative testing, a Millennium Urine Drug Test panel can be ordered. The UDS service contracted to SCF (Millennium Labs) uses quantitative testing which is highly sensitive and specific to the agents being tested; that is to say, if it is in the urine, it will show up on the test. However, based on individual drug kinetics and a person's genetics, a drug's time in the urine can vary. Please look at the following guidance for the use and interpretation of the UDS and what to do if results are unexpected.

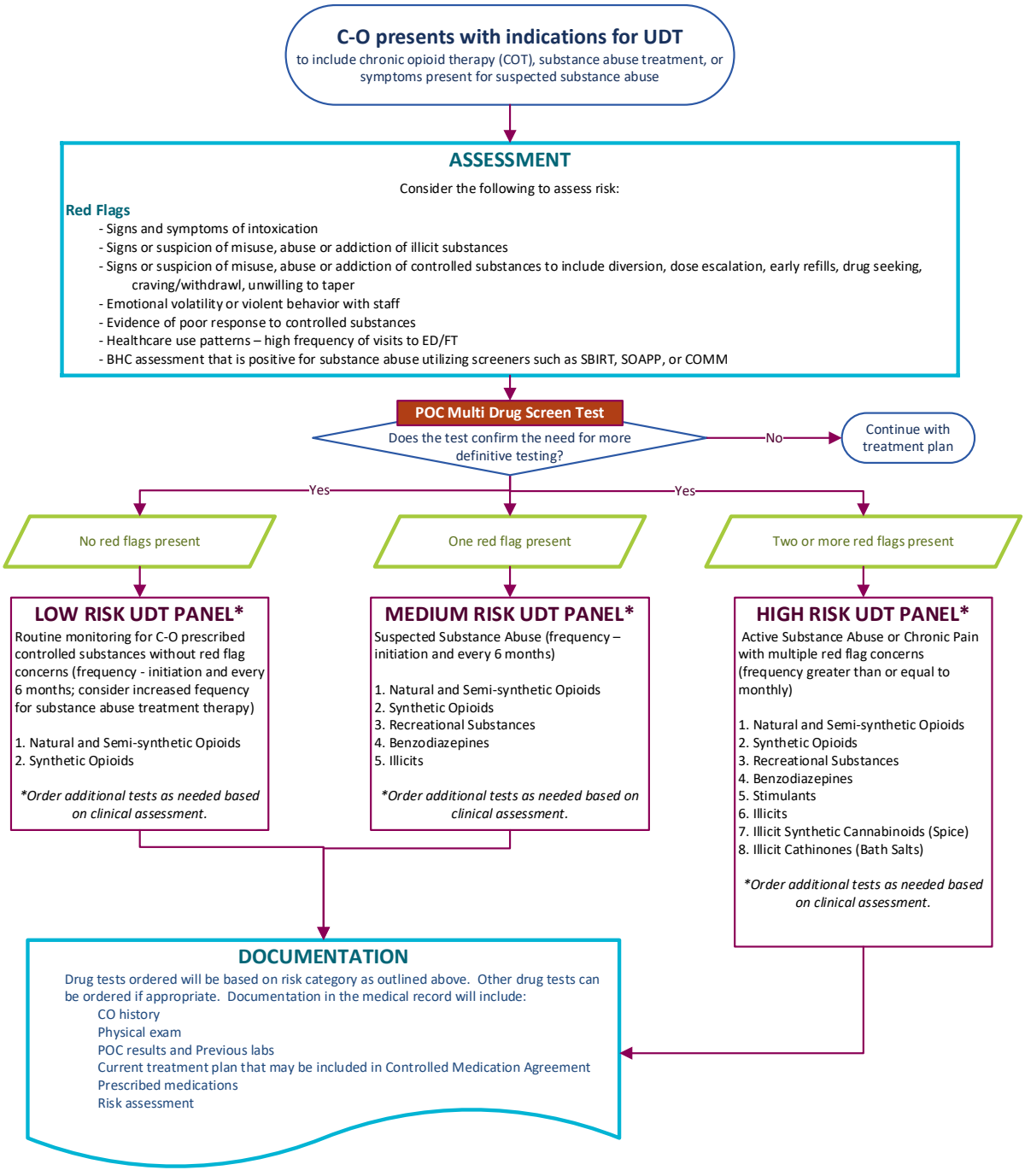
When to Order a UDS

- At the initiation of any controlled medication therapy, including opioids, benzodiazepines, and stimulants.
- Randomly during therapy, ideally between fills, and at least every 6 months.
- If any care-team member suspects misuse, abuse, diversion, or illicit substance use

Ordering UDS

- Follow Non-emergent Urine Drug Test Order Protocol (below) utilizing POC multidrug screening as an initial qualitative test.
- Make sure to include the current pain medications C-O is taking in the comments field of the UDS order. This ensures that the cover page of the scanned results includes a section on expected positives, unexpected negatives, and unexpected positives
- Millennium urine drug panel results are usually seen within 72 working hours.
- The Millennium UDT RADAR report can be found on p.36 of this document
- Millennium drug panel details can also be found on the SCF Primary Care SharePoint site under the Wellness Care Plan Documents tab under Pain Medication heading

NON-EMERGENT URINE DRUG TEST ORDER GUIDELINE



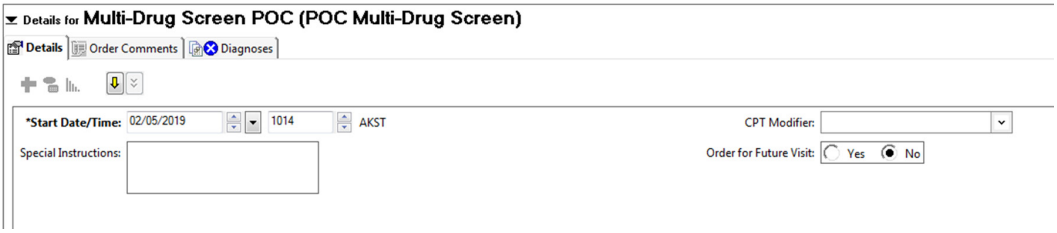
ORDERING / PROPOSING POC MULTI-DRUG SCREEN

1. Search for the order "POC Multi-Drug Screen".

   Note: "Multi-Drug Screen POC" is another name for this order.

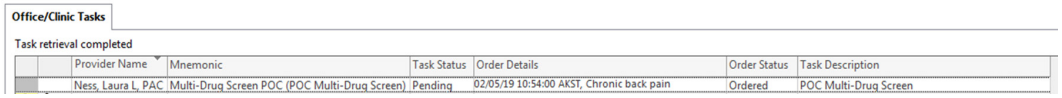
   Multi-Drug Screen POC
   POC Multi-Drug Screen

2. Add an appropriate diagnosis and sign the order.

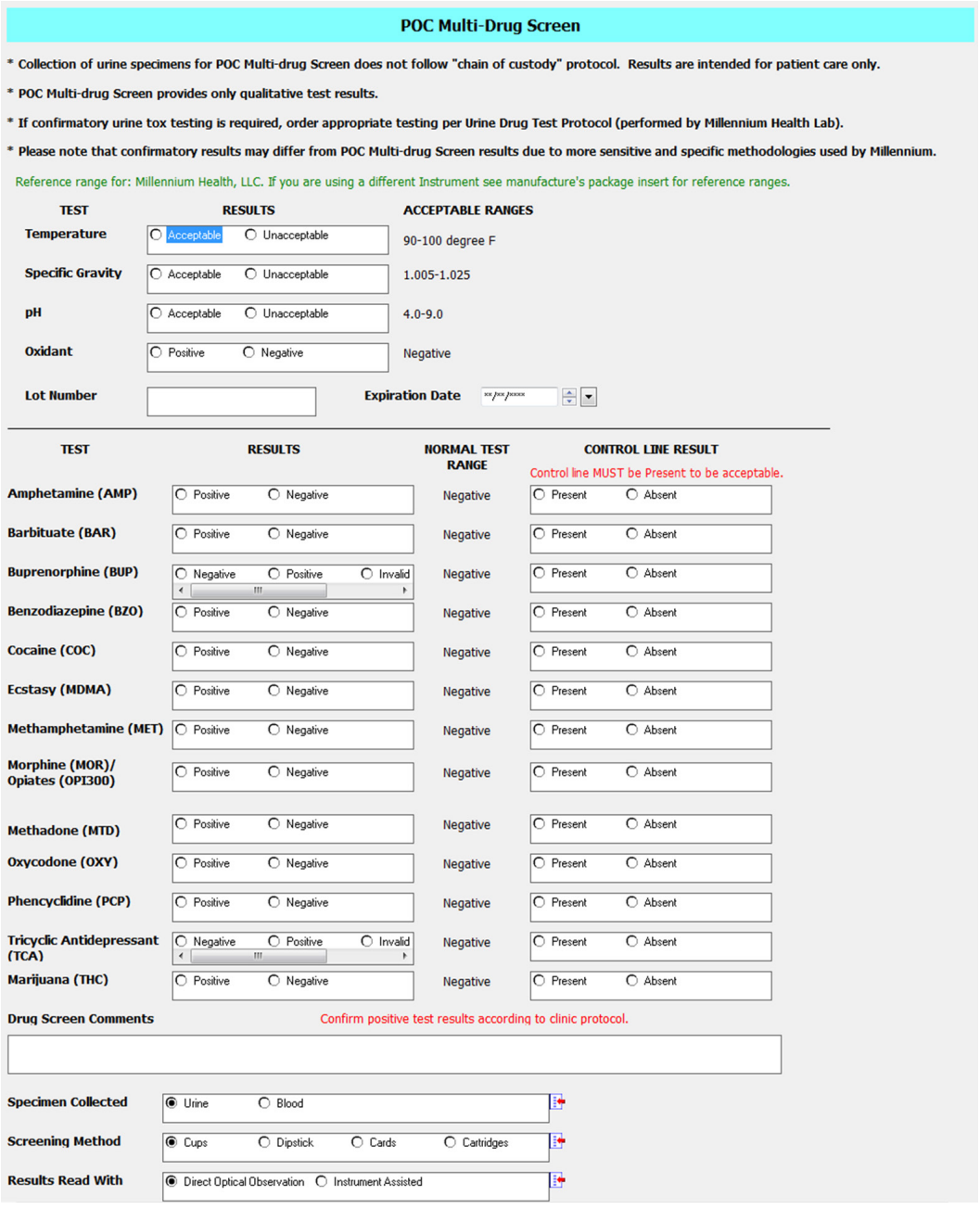


COMPLETING POC MULTI-DRUG SCREEN RESULTS

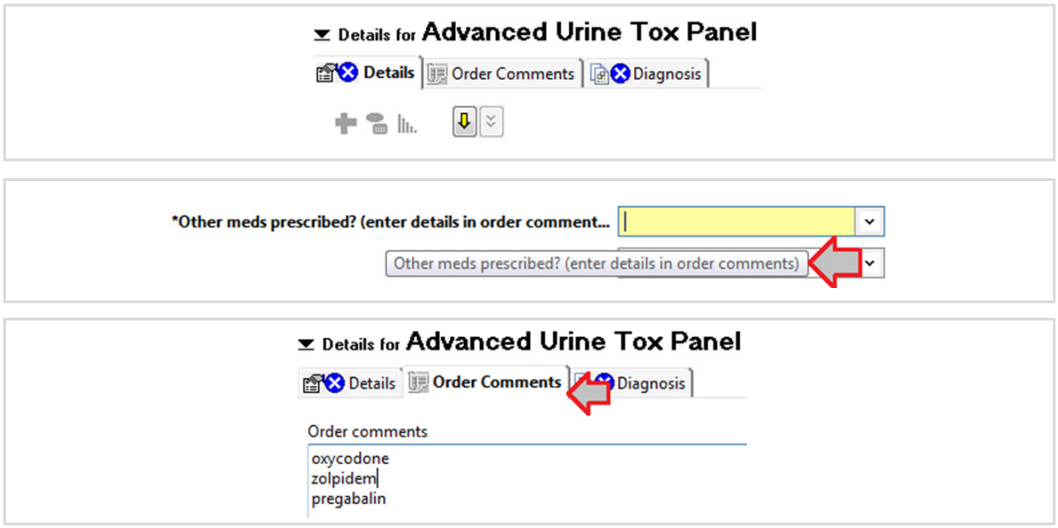
1. CMA opens task from Activities & Interventions



2. CMA enters results into PowerForm:



For the Millennium Urine Drug Test Panel:



Above are screenshots to where the u-tox panels can be found in Cerner.

COLLECTING URINE

ALWAYS ASK THE C-O WHEN THEY TOOK THEIR LAST DOSE OF SCREENED MEDICATIONS

- This removes most questions about whether or not a medication should appear positive on their urine drug screen
- Chart the last dose

What to do with unexpected results

- Unexpected negatives
  - o Review medication fill history to determine if C-O is current with thei prescriptions (i.e. look for gaps in therapy)
    - Contact C-O, as needed, to confirm last dose taken

IF UNEXPECTED NEGATIVES ARE SUSPECTED TO BE MISUSE, ABUSE OR DIVERSION, REFER C-O TO THE OPIOID REVIEW COMMITTEE (ORC) TO ASSESS WHETHER C-O SHOULD BE ELIGIBLE TO RECEIVE CHRONIC CONTROLLED SUBSTANCES AT ANMC

- Unexpected Positives
  - o For prescription medications, review medication fill history and Alaska PDMP (see appendix 3) to determine if positive medication was prescribed
    - Prescribers, RN Case Managers and Pharmacists may be granted access

FOR UNPRESCRIBED AND UNREPORTED MEDICATIONS AND ILLICIT SUBSTANCES REFER TO ORC

Consult with integrated pharmacist for any question about interpretation of UDS results and medication history

The following tables are from Millennium Laboratories:

MILLENNIUM LABORATORIES URINE DRUG SCREEN AVERAGE DETECTION TIMES*

DRUG	DETECTION TIME IN URINE
Amphetamine/Methamphetamine	3-5 Days
Barbiturates : Amobarbital Butalbital Pentobarbital Phenobarbital	 3-8 Days 7-18 Days 4-6 Days 10-30 Days
Benzodiazepines: Alprazolam Clonazepam Diazepam Lorazepam Oxazepam Temazepam	 1-5 Days 4-12.5 Days 5-8 Days 2-3.5 Days 1-2 Days 1-3 Days
Cocaine	2-3 Days
Methadone	3-11 Days
Heroin	< 24 Hours
Opioids	3 Days
Phencyclidine	7 Days
Marijuana	3-5 Days single use (longer for chronic use)

* Does not represent the entire contents of the urine drug screen
* Larger list of drugs and detection time in urine on the SharePoint Wellness Care Plan tab under "Pain" Heading, then "Pain Medication" folder.

COMMON DRUGS OF ABUSE WITH METABOLITES

PARENT DRUG	METABOLITES
Benzodiazepines:	
Alprazolam	alpha-hydroxyalprazolam
Clonazepam	7-aminoclonazepam
Chlorazepate	nordiazepam, oxazepam
Chlordiazepoxide	nordiazepam, oxazepam
Diazepam	nordiazepam, oxazepam, temazepam
Lorazepam	mostly excreted as parent drug
Nordiazepam	oxazepam
Oxazepam	mostly excreted as parent drug
Temazepam	oxazepam
Buprenorphine	Norbuprenorphine
Codeine	morphine, norhydrocodone, hydrocodone, hydromorphone
Fentanyl	Norfentanyl
Heroin	6-acetylmorphine, morphine
Hydrocodone	norhydrocodone, hydromorphone
Hydromorphone	mostly excreted as parent drug
Methadone	EDDP (2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine)
Morphine	Hydromorphone, hydrocodone (minor)
Oxycodone	oxymorphone, noroxycodone
Oxymorphone	mostly excreted as parent drug

SPECIAL NOTE ABOUT AMPHETAMINE & METHAMPHETAMINE

There are a few substances (see table below) that may be amphetamine/methamphetamine positive in Cerner results. If there is any question, call the ANMC lab and ask for the l-amphetamine and l-methamphetamine test to CONFIRM non-controlled sources. Controlled sources will be listed in the Alaska PDMP.

Drug (Active agent)	Metabolizes to:	AMP/MAMP Ratio
Illicit Methamphetamine (*d*-methamphetamine)	*d*-amphetamine and may contain small amounts of *l*-amphetamine	0.04 – 0.37
Didrex[®] [τ] (benzphetamine)	*d*-amphetamine and *d*-methamphetamine	0.53 – 11.17
Desoxyn[®] [ττ] (*d*-methamphetamine)	*d*-amphetamine	0.1 – 2.6
Eldepryl[®], **Emsam**[®] **Zelapar**[®] (selegiline)	*l*-amphetamine and *l*-methamphetamine	0.28 – 0.36
Vicks[®] **Nasal Inhaler** *(OTC)* (*l*-methamphetamine)	*l*-amphetamine (conversion is relatively slow).	0.0 – 0.12

*Chart from Millennium™ Labs

MILLENNIUM LABORATORIES

MILLENNIUM UDT
RADAR™ Report
Consistency and Validity Results

RADAR™ Hotline
866.866.0605
5:00AM - 9:00PM PT, Monday-Friday
7:00AM - 3:30PM PT, Saturday, Sunday

Patient Name: **PATIENT, PAIN**
Patient SSN:
Patient DOB:

Requesting HCP[1]: Doctor Doctor
Requesting Practice: Demo Clinic

Specimen ID: 1405080440
Accession ID: AA4972492
Original Report
05/09/2014 Original

Specimen Outcome: POSITIVE
Specimen Type: Urine

Collected: 05/07/14
Received: 05/08/14
Tested: 05/09/14
Completed: 05/09/14

CONSISTENT RESULTS - REPORTED MEDICATION DETECTED (PARENT DRUG AND/OR METABOLITE)

REPORTED MEDICATION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	COMMENTS
PERCOCET	Oxycodone	POSITIVE	The sample tested positive for Oxycodone, Oxymorphone which is consistent with patient having taken PERCOCET
	Noroxycodone	Negative	
	Oxymorphone	POSITIVE	
SOMA	Carisoprodol	POSITIVE	The sample tested positive for Carisoprodol, Meprobamate which is consistent with patient having taken SOMA
	Meprobamate	POSITIVE	

INCONSISTENT RESULTS - REPORTED MEDICATION NOT DETECTED (NEITHER PARENT DRUG NOR METABOLITE)

REPORTED MEDICATION	ANTICIPATED POSITIVE(S)	DETECTION WINDOW	COMMENTS
XANAX	Alpha-Hydroxyalprazolam	2 - 5 days after last dose. Higher doses & certain pathologies may extend the detection window.	The sample tested negative for Alpha-Hydroxyalprazolam which suggests the patient is not currently taking XANAX (within the detection window)

INCONSISTENT RESULTS - ANALYTE DETECTED BUT NO CORRESPONDING MEDICATION REPORTED

DETECTED ANALYTE	DETECTION WINDOW	COMMENTS
Cocaine metabolite	3 - 5 days after last use of cocaine.	Cocaine is a DEA Schedule II controlled substance with very limited licit pharmaceutical application.
JWH018 metabolite	Urinary detection window not established. The detection window for related drugs, including cannabinoids, can be days to weeks and is highly dependent on the frequency of use.	A metabolite of a synthetic cannabinoid JWH018 commonly found in preparations known as SPICE and K2.

SPECIMEN VALIDITY RESULTS

TEST (MEASUREMENT UNIT)	TEST OUTCOME	MEASURED RESULT	REFERENCE RANGE
CREATININE (mg/dL)	Normal	21	>20 mg/dL
OXIDANT (ug/mL)	Normal	0	<200 ug/mL
pH	Normal	7.2	4.5 - 9.5
SPECIFIC GRAVITY	Normal	1.021	1.003 - 1.050

MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

SENOKOT

(1) Healthcare Provider (HCP)

The consistency section provides interpretive assistance based on recognized pharmaceutical and pharmacokinetic data, but may not cover all drug use scenarios or clinical circumstances. In making treatment decisions, it should be used together with clinical observation and professional judgment. Additional interpretive assistance is available through the RADAR hotline. The medication information reported here and on the requisition form has been provided by the requesting clinician and has not been verified by Millennium Laboratories.
Millennium's consistency section utilizes LC-MS/MS data only and does not include results for EIA, ELISA or Chemical assays. Results from these assays are reported in the Tabulated Results section. If not included here, the Tabulated Results section is available online or by contacting the RADAR Hotline.
Specimen collection date is reported by the referring provider and is not verified by Millennium Laboratories. When no collection date is provided, Millennium Laboratories reports the business day prior to receipt at the laboratory. Precise information about collection date, if necessary, must be obtained from the medical records of the referring provider.

MILLENNIUM LABORATORIES

MILLENNIUM UDT
RADAR™ Report
Comparative and Historical Results

RADAR™ Hotline
866.866.0605
5:00AM - 9:00PM PT, Monday-Friday
7:00AM - 3:30PM PT, Saturday, Sunday

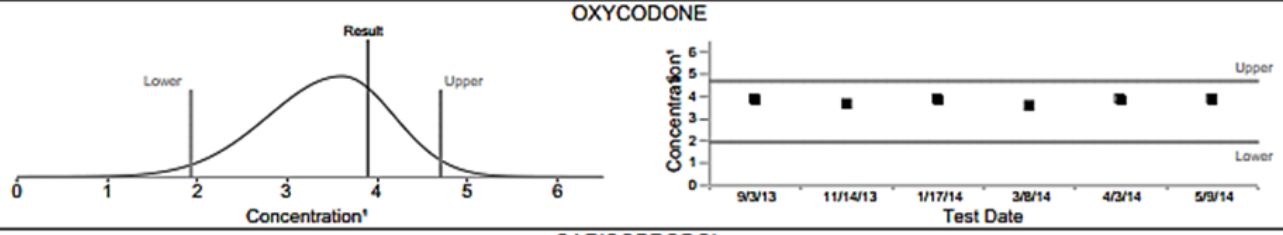
COMPARATIVE RESULTS

The following graph(s) present the patient's current UDT results in relation to the frequency distribution of positive UDT values(2) for all patients with a reported medication for the named medications tested by Millennium.(3) The section of each graph between the upper and lower limits represents the 95% inclusion range.(4)
The information is provided as a clinical tool and is not intended to indicate a patient's adherence to a prescribed medication dosage.

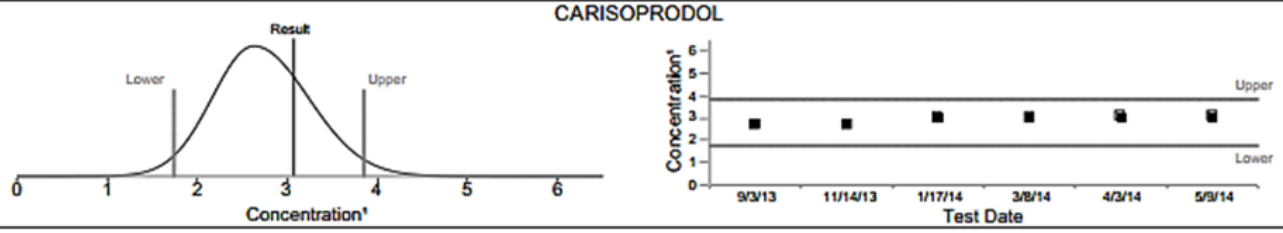
HISTORICAL RESULTS

The following graph(s) present (up to) the last six UDT results (since 12/2010) for this patient.(2) The section of each graph between the upper and lower limits represents the 95% inclusion range.(4)
The information is provided as a clinical tool and is not intended to indicate a patient's adherence to a prescribed medication dosage.

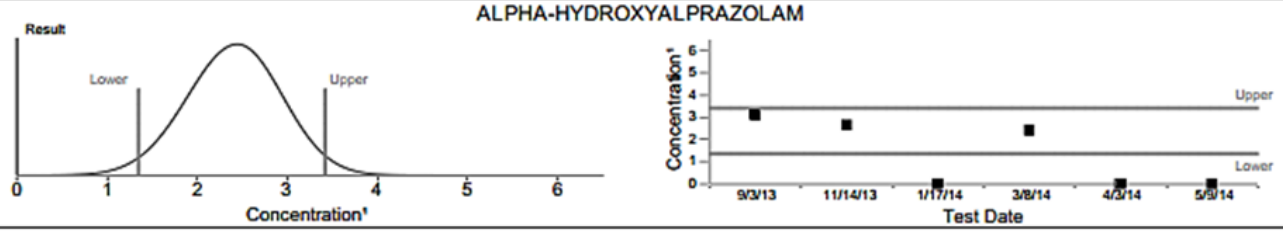
OXYCODONE



CARISOPRODOL



ALPHA-HYDROXYALPRAZOLAM



HISTORICAL RESULTS - TESTING HISTORY

Visit #	Test Date	Specimen ID	Visit #	Test Date	Specimen ID	Visit #	Test Date	Specimen ID
Current	5/9/2014	1405080440	B	3/8/2014	1396281615	D	11/14/2013	1401171631
A	4/3/2014	1404031636	C	1/17/2014	1403051245	E	9/3/2013	1401062713

(1) Expressed as the creatinine-corrected concentrations (ng drug/mg creatinine). (2) Expressed as the Log of the creatinine-corrected concentrations. The frequency distributions are acquired from the entire ML data set for patients taking the named medication with the reported medication. The data set has not been adjusted to demographic or prescription dosage information. (3) Comparative and Historical results are available for prescribed morphine, hydrocodone, oxycodone, buprenorphine,

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TEST	TEST METHOD	TEST OUTCOME	MEASURED RESULTS*	CREATININE NORMALIZED RESULTS**	CUTOFF*
NATURAL AND SEMI-SYNTHETIC OPIOIDS					
Codeine	LC-MS/MS	Negative		-	50
Morphine	LC-MS/MS	Negative		-	50
Hydrocodone	LC-MS/MS	Negative		-	50
Norhydrocodone	LC-MS/MS	Negative		-	50
Hydromorphone	LC-MS/MS	Negative		-	50
Oxycodone	**LC-MS/MS**	**POSITIVE**	**1,577**	**7,509**	**50**
Noroxycodone	LC-MS/MS	Negative		-	50
Oxymorphone	**LC-MS/MS**	**POSITIVE**	**118**	**561**	**50**
Buprenorphine	LC-MS/MS	Negative		-	10
Norbuprenorphine	LC-MS/MS	Negative		-	20
SYNTHETIC OPIOIDS					
Fentanyl	LC-MS/MS	Negative		-	2
Norfentanyl	LC-MS/MS	Negative		-	8
Methadone	LC-MS/MS	Negative		-	100
EDDP (Methadone metabolite)	LC-MS/MS	Negative		-	100
Propoxyphene	LC-MS/MS	Negative		-	100
Norpropoxyphene	LC-MS/MS	Negative		-	100
Tramadol	LC-MS/MS	Negative		-	100
O-desmethyl-tramadol	LC-MS/MS	Negative		-	100
N-desmethyl-tramadol	LC-MS/MS	Negative		-	100
Tapentadol	LC-MS/MS	Negative		-	50
Meperidine	LC-MS/MS	Negative		-	50
Normeperidine	LC-MS/MS	Negative		-	50
BENZODIAZEPINES					
Alpha-Hydroxyalprazolam	LC-MS/MS	Negative		-	20
7-Amino-Clonazepam	LC-MS/MS	Negative		-	20
Lorazepam	LC-MS/MS	Negative		-	40
Nordiazepam	LC-MS/MS	Negative		-	40
Temazepam	LC-MS/MS	Negative		-	50
Oxazepam	LC-MS/MS	Negative		-	40
STIMULANTS					
Amphetamine	LC-MS/MS	Negative		-	100
Methylphenidate	LC-MS/MS	Negative		-	50
Ritalinic Acid	LC-MS/MS	Negative		-	50
SSRIs / SNRIs					
Duloxetine	LC-MS/MS	Negative		-	25
Fluoxetine	LC-MS/MS	Negative		-	25
Norfluoxetine	LC-MS/MS	Negative		-	25
Paroxetine	LC-MS/MS	Negative		-	25
Venlafaxine	LC-MS/MS	Negative		-	100
Desmethylvenlafaxine	LC-MS/MS	Negative		-	100
OTHER					
Gabapentin	LC-MS/MS	Negative		-	100
Pregabalin	LC-MS/MS	Negative		-	100
Ketamine	LC-MS/MS	Negative		-	50
Norketamine	LC-MS/MS	Negative		-	50
Naltrexone	LC-MS/MS	Negative		-	10
Naltrexol (Naltrexone metabolite)	LC-MS/MS	Negative		-	10
Zolpidem	LC-MS/MS	Negative		-	10
cZolpidem (Zolpidem metabolite)	LC-MS/MS	Negative		-	10
Carisoprodol	**LC-MS/MS**	**POSITIVE**	**241**	**1,147**	**100**
Meprobamate	**LC-MS/MS**	**POSITIVE**	**153**	**728**	**100**
Phenobarbital	LC-MS/MS	Negative		-	200
Secobarbital	LC-MS/MS	Negative		-	200

Original Report
Specimen Outcome: **POSITIVE**
Specimen Type: **Urine**
Specimen ID: **1405080440**
Accession ID: **AA4972492**

Patient Name: **PATIENT, PAIN**

Patient SSN:
Patient DOB:

Requesting HCP[1]: Doctor Doctor
Requesting Practice: Demo Clinic

SPECIMEN VALIDITY RESULTS

TEST (MEASUREMENT UNIT)	TEST OUTCOME	MEASURED RESULT	REFERENCE RANGE
CREATININE (mg/dL)	Normal	21	>20 mg/dL
OXIDANT (ug/mL)	Normal	0	<200 ug/mL
pH	Normal	7.2	4.5 - 9.5
SPECIFIC GRAVITY	Normal	1.021	1.003 - 1.050

THE FOLLOWING MEDICATIONS WERE REPORTED ON THE REQUISITION FORM[2,3]

PERCOCET, SENOKOT, SOMA, XANAX

COMMENTS

Specimen History
Collected: 05/07/14
Received: 05/08/14
Tested: 05/09/14
Completed: 05/09/14

Report History
05/09/2014 Original

(1) Healthcare Provider (HCP)

(2) The medications reported here and on the test requisition form have not been verified by Millennium Laboratories. This report is not intended to replace the patient's official medical records.

(3) Millennium Laboratories makes every effort to amend entries on requisition forms that may be misspelled or illegible. Please be advised that when a reported medication is not recognized by our data management system because of a misspelling, then the reported medication will appear here using the same misspelling.

NOTES

ALL TESTING PERFORMED BY MILLENNIUM LABORATORIES AND CERTIFIED BY CLINICAL LABORATORY SCIENTISTS.
Reference ranges have not been established for urine specimens.
Creatinine normalized values are for clinical pharmacokinetic comparison only.
Interpretation of the presumptive EIA results must be combined with clinical observation and professional judgment.
These test results are to be used for medication monitoring of patients and not for employment-related purposes.
Specimen collection date is reported by the referring provider and is not verified by Millennium Laboratories. When no collection date is provided, Millennium Laboratories reports the business day prior to receipt at the laboratory. Precise information about collection date, if necessary, must be obtained from the medical records of the referring provider.

EIA results are considered presumptive. In the event of contrary EIA vs. LC-MS/MS results, Millennium Laboratories recommends relying on the LC-MS/MS.

Millennium Laboratories, LLC
16981 Via Tazon, San Diego, CA 92127 - FAX 858.451.3636
Lab Director: Amadeo Pesce, PhD, DABCC, CLIA ID# 05D10 78705

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TEST	TEST METHOD	TEST OUTCOME	MEASURED RESULTS*	CREATININE NORMALIZED RESULTS**	CUTOFF*
Butalbital	LC-MS/MS	Negative		-	200
Amitriptyline	LC-MS/MS	Negative		-	50
Nortriptyline	LC-MS/MS	Negative		-	50
Imipramine	LC-MS/MS	Negative		-	50
Desipramine	LC-MS/MS	Negative		-	50
Cyclobenzaprine	LC-MS/MS	Negative		-	50
ILLICITS					
Methamphetamine	LC-MS/MS	Negative		-	100
Cocaine metabolite	LC-MS/MS	POSITIVE	67	319	50
cTHC (Marijuana metabolite)	LC-MS/MS	Negative		-	10
MDMA	LC-MS/MS	Negative		-	100
6-MAM (Heroin metabolite)	LC-MS/MS	Negative		-	10
Phencyclidine	LC-MS/MS	Negative		-	10
ILLICITS - SYNTHETIC CANNABINOIDS (Spice)					
AM2201 metabolite	LC-MS/MS	Negative		-	10
MAM2201 metabolite	LC-MS/MS	Negative		-	10
JWH018 metabolite	LC-MS/MS	POSITIVE	18	85	10
JWH073 metabolite	LC-MS/MS	Negative		-	10
JWH081 metabolite	LC-MS/MS	Negative		-	10
JWH122 metabolite	LC-MS/MS	Negative		-	10
JWH210 metabolite	LC-MS/MS	Negative		-	10
JWH250 metabolite	LC-MS/MS	Negative		-	10
RCS4 metabolite	LC-MS/MS	Negative		-	10
RCS4 metabolite #9	LC-MS/MS	Negative		-	10
XLR11/UR144 metabolite	LC-MS/MS	Negative		-	10
ILLICITS - CATHINONES (Bath salts)					
MDPV	LC-MS/MS	Negative		-	3
Mephedrone	LC-MS/MS	Negative		-	3
Methylone	LC-MS/MS	Negative		-	3
RECREATIONAL SUBSTANCES					
Ethyl Glucuronide	LC-MS/MS	Negative		-	500
Ethyl Sulfate	LC-MS/MS	Negative		-	500

* measured in ng/mL (nanogram of analyte per milliliter of urine)
** measured in µg/g (microgram of analyte per gram of creatinine)

Original Report
Specimen Outcome: **POSITIVE**
Specimen Type: **Urine**
Specimen ID: **1405080440**
Accession ID: **AA4972492**

Patient Name: **PATIENT, PAIN**

Patient SSN:
Patient DOB:

Requesting HCP¹: Doctor Doctor
Requesting Practice: Demo Clinic

ADDITIONAL TEAM MEMBERS AT OPIOD DOSES

At 90 mg of morphine equivalents or greater, these doses are **RED FLAGS** and require consultation with Pain Consultant PM&R, BHC, and pharmacist. **INDISCRIMINANTE DOSE REDUCTIONS SHOULD BE AVOIDED.**

Doses over 90 mg morphine equivalent per day (see drug table) should be avoided if possible

As opioid doses increase, so do potential adverse effects. Doses of over 50 mg of morphine equivalents require close scrutiny to ensure that benefits outweigh risks and that all appropriate non-opioid therapies and non-medical treatment modalities are being considered.
Reasons to restrict or decrease opioid doses over the 50 mg morphine equivalents include:

- Higher rates of overdose and death
- Greater difficulty in tapering down
- More difficulty controlling acute pain
- Higher rates of mental health and substance abuse disorders
- Higher rates of falls and fractures in the elderly
- Less likely to improve function or ability to work
- Higher rates of endocrinopathy (i.e. low libido, fertility)
- Higher rates of immune dysfunction

At doses over 50 morphine equivalents, management is expected to include:

- Urine toxicology and pill counts every **3 months** at minimum
- Sleep study to screen for sleep apnea
- Involvement of Pain Consultant PM&R and/or Care Conference
- Low threshold for ORC referrals for any aberrant behaviors or lack of adherence to treatment plan
- Ensuring benefits are objective, utilizing BHC functional evaluations

TERMINATION

WHEN TO CONSIDER OPIOID TAPER

The following list includes events and behaviors that may lead a provider to consider an opioid taper. Please **consider a referral to the Opioid Review Committee (ORC)** given that the decision to taper opioids is often prompted by one or more high-risk behaviors. While a referral to the ORC is not required, it can enhance cross-campus communication and aid in future decision-making regarding pain treatment. Red flags to watch for may include:

- Frequent requests for dose escalations
- Frequently lost or stolen medications
- Primary focus is on opioids above other treatments
- Aggressive/disruptive behavior in clinic
- History of suicidal or psychotic behavior
- Substance use disorder, especially if active or a history of overdose (unintentional or intentional)
- Not showing to repeated office visits, urine toxicology requests, and/or pill counts
- Not upholding SCF Controlled Medication Agreement

WHEN TO CONSIDER OPIOID TERMINATION

Deciding to terminate opioids generally occurs for at least one of three reasons:

1. The C-O is or has recently behaved dangerously due to the effects of illicit drugs and/or controlled medications.
2. The C-O has demonstrated that they are not taking their prescribed opioid medications.
3. The C-O is getting additional, routine opioid prescriptions from another source.

In the first scenario, if a C-O is intoxicated or obtunded, the risk of additional opioid prescribing (including a taper) is very high and may lead to death. If the C-O is opioid-dependent, this may lead to opioid withdrawal. See below for management considerations.

The other two scenarios should not lead to opioid withdrawal. If repeated urine toxicology demonstrates that a C-O is negative for the prescribed medication despite a careful history of recent reported ingestion, this raises concerns for diversion and it can be assumed that the C-O is not taking the medication. Concerns of diversion also arise when it is discovered, often by using the Alaska PDMP, that they are receiving redundant scripts from other providers.

OPIOIDS SHOULD BE STOPPED IMMEDIATELY IF C-O PRESENTS WITH THESE BEHAVIORS:

- Obtunded
- Positive for illegal substances or negative urine drug screens
- Receiving opioid prescriptions from another source
- Intoxication in Emergency Department or other clinic visit

OPIOID TAPER AND TERMINATION MANAGEMENT OPTIONS

If a **taper** of opioid medication is desired, this should be planned in conjunction with an integrated pharmacist. The goal of a taper is to minimize the effects of opioid withdrawal. There are many variables that will determine the speed and length of a taper, and so a customized plan should be designed for each C-O. Close follow-up is recommended during the taper to ensure adherence and success.

When **terminating** an opioid-dependent C-O's opioids due to safety issues, there are several management decisions. In cases with a negative urine drug screen for prescribed opioids or redundant scripts from an outside provider, no further pharmacological management is necessary. A behavioral health consultant (BHC) should be involved in all cases to help connect C-Os to resources and to assist with behavioral needs. Given that access to some resources often requires a waiting period, **all C-Os should be offered non-opioid medications to mitigate the effects of opioid withdrawal**. In conjunction, a primary care team may connect a C-O with SCF Detox, as this clinic can provide more intensive acute services and potentially serve as a bridge to medication assisted therapies (MAT) upon discharge. **All C-Os with an opioid use disorder that will no longer be receiving opioids from their primary care provider should be connected to Four Directions** for a personalized assessment and intensive outpatient services. This may include MAT.

Note that a DEA waiver is required to prescribe buprenorphine and methadone for opioid withdrawal. As a system, we do not recommend prescribing methadone for opioid withdrawal. Referrals to SCF MAT program or outside programs are recommended.

OPIOID WITHDRAWAL SYMPTOMS:	ACTIVITIES FOR MANAGING OPIOID WITHDRAWAL SYMPTOMS
Abdominal cramps	Drink adequate water
Anxiety	Eat regular nutritious meals
Diaphoresis	Use diaphragmatic breathing
Diarrhea	Stretching
Goose bumps	Exercise in moderation
Hypertension	Relaxation activity (e.g. relaxing music)
Insomnia	Follow recommended taper schedule
Lacrimation	Use distraction (humor, social gatherings)
Muscle twitching	Positive self-talk ("I can do this")
Nausea/Vomiting	
Rhinorrhea	
Tachycardia	
Tachypnea	

MEDICATIONS FOR AMBULATORY TREATMENT OF OPIOID WITHDRAWAL

NAME	FORMULARY OPTIONS	NOTES
Ondansetron	4 & 8 mg tablet 4 mg ODT*	For nausea/vomiting, possible reduction in motor symptoms BID or TID dosing, scheduled during taper until resolution of sx
Hydroxyzine pamoate	25 mg capsule	For anxiety and/or nausea/vomiting, Salt form irrelevant. Dose 50-100 mg QID for anxiety Dose 10-25 mg PRN nausea/vomiting (MAX 4x/day)
Hydroxyzine HCl	10, 25 mg tablet	
Clonidine	0.1 mg tablet 0.1 mg patch	For noradrenergic sx (tachycardia, HTN, insomnia, etc.) Tablet: TID dosing (not preferred) Patch: once weekly (preferred for 24 hour coverage and adherence)

*ODT = oral disintegrating tablet

INDICATIONS FOR REFERRALS TO THE OPIOID REVIEW COMMITTEE (ORC):

ORC's purpose is to make decisions about eligibility of a C-O to continue to receive opioid pain medications. There are a number of concerning behaviors and risk factors that prompt a provider to consider a referral to the ORC, including:

- Overuse of controlled medications (including opioids, benzodiazepines and sedatives)
- Frequent lost prescriptions
- Early refills
- Focus on narcotic/addictive medications at visits
- Aggressive or threatening behavior with staff surrounding medication(s)
- History of untreated mental health issues
- Active substance use (alcohol, marijuana, street drugs)
- Behaviors associated with opioid use that are considered high risk for abusing opioid medications
- History of abusing several different substances such as alcohol, illegal drugs, etc.
- Breaking the SCF Controlled Medication Agreement
- Or any other cause for concern not listed above

MEANING OF "RESTRICTED CONTROLLED SUBSTANCE" STATUS

In the setting of an SCF Controlled Substances Agreement or Wellness Care Plan, it is important to know the meaning of the term "Restricted Controlled Substance." Only the ORC can officially recommend that a C-O's chart be labeled "Restricted Controlled Substance." A determination of restriction does not prevent a provider from prescribing opioids for the C-Os. The "Restricted Controlled Substance" identifier serves as a strong warning that there are risks present in prescribing opioids for this particular C-O – "Proceed with Caution".

PROVIDERS SHOULD NOT PRESCRIBE CHRONIC CONTROLLED SUBSTANCES TO SOMEBODY THAT HAS BEEN DEEMED OPIOID RESTRICTED. THIS STATUS CAN BE SEEN IN THE BANNER BAR AS "RESTRICTED CONTROLLED SUBSTANCES" AND THE ORC NOTE CAN BE FOUND IN THE CHART UNDER PAIN NOTES. C-Os WILL HAVE ALSO BEEN NOTIFIED OF THEIR OPIOID RESTRICTED STATUS. ACUTE SITUATIONS, CONDITIONS, OR INJURIES ARE AN EXCEPTION.

INDICATIONS FOR REFERRAL TO A SUBSTANCE ABUSE TREATMENT CLINIC

Indications for referral to a Substance Abuse Treatment Clinic overlap those that may indicate referral to the ORC. An important definition to review to understand indication for referral is **substance use disorder**: characterized by a persistent pattern of dysfunctional opioid use that may involve (a) loss of control over the use of opioids, (b) preoccupation with obtaining opioids, despite the presence of adequate analgesia, and (c) continued use despite physical, psychological, or social adverse consequences. Given this, indications for referral include:

- If a C-O has developed behaviors suggesting substance use disorder to either the prescribed opioids or any other substance use disorder (illicit drugs, alcohol).
- If there is a need to taper but the C-O is unable to tolerate tapering despite discontinuation of the SCF Controlled Medication Agreement.

If a referral is warranted, please reference the Wellness Care Plan tab on SharePoint and work with a BHC to determine the most appropriate treatment option (12 Step, Outpatient, Residential, etc.)

When considering a referral, the C-O insight and motivation to treat their substance use disorder should always be considered.

Suggested referrals may include, but not limited to:

- ORC
- Care Conference
- SCF Pain Consultant PM&R
- ANTHC Comprehensive Pain Management Clinic
- Suboxone
- SCF Detox
- Four Directions
- Dena A Coy
- Narcotics Anonymous

APPENDIX 1 – EQUIANALGESIC DOSING

Dosing Conversion:

1. Determine the total 24-hour dose of the current opioid
2. Calculate morphine equivalent dose based on conversion table below‡
3. Due to incomplete cross tolerance, reduce total daily morphine equivalent dose by 40% (25-50%)
4. If switching to another opioid, convert new dose based on conversion table on the next page.
5. 80-90% of total daily dose should be reserved for long-acting therapy. VA/DoD (VA Affairs, Department of Defense) Clinical Guideline
6. 10-20% of total daily dose should be reserved for short-acting therapy (breakthrough pain).

‡Recommend that TOTAL opioid dose should not exceed 50 mg of morphine equivalents per day if possible due to safety concerns, and for C-Os taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose.

MORPHINE EQUIVALENT DOSE (MED) FACTOR:

OPIOID	MORPHINE EQUIVALENT FACTOR
Morphine	1
Buprenorphine Patch	12.6[1]
Codeine	0.15
Fentanyl Patch	7.2[2]
Hydrocodone	1
Hydromorphone	4
Meperidine HCl	0.1
Oxycodone	1.5
Oxymorphone	3
Tramadol	0.1

1. MED/day for four 5 µg/hr buprenorphine patches dispensed for use over 28 days would work out as follows: Example: 5 µg/hr buprenorphine patch * (4 patches/28 days)* 12.6 = 9 MME/day
2. MED/day for ten 25 µg/hr fentanyl patches dispensed for use over 30 days would work out as follows: Example: 25 µg/hr fentanyl patch * (10 patches/30 days)* 7.2 = 60 MME/day.

***Fentanyl Transdermal Conversion:** should ONLY be used in C-Os who are already receiving opioid therapy, are opioid-tolerant, and require a daily dose at least equivalent to fentanyl 25 mcg/h. Opioid Tolerant = at least one week at stable dose.

Equivalent to fentanyl 25 mcg/h patch
60 mg morphine total daily
40 mg oral oxycodone total daily
15 mg oral hydromorphone daily
Or equianalgesic dose of another opioid

****Methadone Conversion:**
This is a complicated dosing conversion that is scaled depending on exactly how much daily morphine equivalent a patient is taking. See integrated pharmacist.

APPENDIX 2 NALOXONE PROTOCOL

1. PURPOSE:

1.1. To reduce morbidity and mortality from opioid overdose by implementing a protocol allowing pharmacists to educate, prescribe, and dispense naloxone.

2. SCOPE:

2.1. ANMC pharmacists who have completed an opioid overdose training program may educate, prescribe, and dispense naloxone to an Rural or Anchorage Service Unit customer-owner at risk of opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug to a person at risk for opioid overdose, upon request of the customer-owner or family member/caregiver, based on the criteria below.

3. PROCEDURE:

3.1. Background: The State of Alaska has passed SB23 approving a Hold Harmless law for prescribing, administering, and providing opioid overdose drugs. Health care providers can prescribe directly or through protocol to a person at risk of experiencing an opioid overdose or to a family member, friend, caregiver, or other person in a position to administer an opioid overdose drug to a person at risk of experiencing an opioid overdose.

3.2. Recipient: The person to whom the naloxone will be dispensed to. (The person who presents to the pharmacy)

3.3. At time of presentation to the pharmacy, the pharmacists will screen recipient face-to-face for eligibility to receive naloxone for response to an opioid overdose, meeting any of the criteria of overdose risk; including, but not limited to:

3.3.1. Voluntary request and/or pharmacist judgment

3.3.2. History of substance use disorder or overdose

3.3.3. High dose opioid prescription (≥50 MME/day)

3.3.4. Concurrent benzodiazepine use

3.3.5. Difficulty accessing emergency medical services

3.3.6. Any contraindications to the use of naloxone by the C-O at risk of opioid overdose

3.4. Pharmacists will educate, prescribe, and dispense naloxone prescriptions under the recipient's primary or covering provider, with notable exceptions: un-empaneled customer-owners at VNPCC may be under VNPCC medical director or RASU customer-owners may be under designated SCF primary provider.

3.4.1. Naloxone HCl will be dispensed for nasal administration to the recipient when they present to the pharmacy.

3.4.1.1. Dispense quantity will be at pharmacist's discretion.

3.4.1.2. The refill quantity will be zero refills.

3.5. Pharmacists will provide recipient education on the appropriate use of naloxone.

3.6. Pharmacists will document each naloxone encounter as a prescription and a pharmacist note in EHR and:

3.6.1. Forward notification of naloxone dispensing to the primary or covering provider of the recipient.

3.6.2. Contact the primary or covering provider of the recipient in the event that the pharmacist requires medical consultation for a particular recipient.

3.7. Pharmacists will be trained on overdose prevention and naloxone kits

3.7.1. Pharmacists must complete an initial one hour continuing education specific to the use of an opioid overdose drug.

3.8. Review of protocol will be reported to ANMC's P&T committee annually.

Effective date: 12/16 Approved by: P&T Committee

APPENDIX 3 – STATE OF ALASKA PRESCRIPTION DRUG MONITORING PROGRAM (PDMP)

As of July 17, 2017

- **Mandatory registration** by *all pharmacists* who dispense a federally controlled substance ii, iii and iv *and DEA registered prescribers* licensed in the State of Alaska.
- **Practitioner must review** PDMP information before dispensing, prescribing, or administering a federal schedule II or III controlled substance. **The exception(s) are:**
  - o receiving treatment in an inpatient setting;
  - o at the scene of an emergency or in an ambulance;
  - o in an emergency room;
  - o immediately before, during, or within the first 48 hours after surgery or a medical procedure;
  - o in a hospice or nursing home that has an in house pharmacy;
  - o a non-refillable prescription of a controlled substance in a quantity intended to last for not more than three days.
- **Collection** of all schedule II, III, or IV controlled substances dispensed in the state; schedule V controlled substances are no longer collected.
- **Delegate access** is now allowed, but with limitations; a registered pharmacist or prescriber may allow access to the PDMP by an agent or employee, who is licensed or registered under AS 08, by creating a sub-account within the PDMP under their corresponding prescriber or pharmacist account. Sign up instructions for delegates are coming soon.
- **Unsolicited reports** may be provided to both prescribers and pharmacists when a patient appears to be receiving multiple Schedule II-IV prescriptions from multiple pharmacies and multiple prescribers; the current threshold is set at 5 prescribers / 5 dispensers in a 3-month period.
- **Reporting frequency** of controlled substances dispensed will change to weekly.

FOR FURTHER READING ON THE ABOVE SECTIONS, PLEASE REFER TO THE FOLLOWING SOURCES:

Pain:

http://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1698&navItemNumber=576

Defining Non-cancer Pain:

Michael R. Von Korff

Opioids for Chronic Noncancer Pain: As the Pendulum Swings, Who Should Set Prescribing Standards for Primary Care?

Ann Fam Med July/August 2012 10:302-303; doi:10.1370/afm.1422

Significance of a 90 Day Infection Point:

Korff MV, Saunders K, Thomas Ray G, et al. De facto long-term opioid therapy for noncancer pain. Clin J Pain. Jul-Aug 2008;24(6):521-527.

Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. J Gen Intern Med. Dec 2011;26(12):1450-1457.

Braden JB, Fan MY, Edlund MJ, Martin BC, DeVries A, Sullivan MD. Trends in use of opioids by noncancer pain type 2000-2005 among Arkansas Medicaid and HealthCore enrollees: results from the TROUP study. J Pain. Nov 2008;9(11):1026-1035

Conditions That Opioids Might Harm:

Sullivan MD, Ballantyne JC. What are we treating with chronic opioid therapy? Arch Int Med. 2012;172(5):433-434.

Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. J Gen Intern Med. Dec 2011;26(12):1450-1457.

Schwartz AC, Bradley R, Penza KM, et al. Pain medication use among patients with posttraumatic stress disorder. Psychosomatics. Mar-Apr 2006;47(2):136-142.

Seal KH, Shi Y, Cohen G, Maguen S, Krebs EE, Neylan TC. Association of mental health disorders with prescription opioids and high-risk opioid use in US veterans of Iraq and Afghanistan. JAMA. 2012;307(9):940-947.

Red Flags:

Morasco BJ, Duckart JP, Carr TP, Deyo RA, Dobscha SK. Clinical characteristics of veterans prescribed high doses of opioid medications for chronic non-cancer pain. Pain. Dec 2010;151(3):625-632.

Edlund MJ, Martin BC, Fan MY, Devries A, Braden JB, Sullivan MD. Risks for opioid abuse and dependence among recipients of chronic opioid therapy: results from the TROUP study. Drug Alcohol Depend. Nov 1 2010;112(1-2):90-98.

Weisner CM, Campbell CI, Ray GT, et al. Trends in prescribed opioid therapy for non-cancer pain for individuals with prior substance use disorders. Pain. Oct 2009;145(3):287-293.

Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med. Jan 19 2010;152(2):85-92.

Martin BC, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD. Long-term chronic opioid therapy discontinuation rates from the TROUP study. J Gen Intern Med. Dec 2011;26(12):1450-1457.

Edlund MJ, Martin BC, Fan MY, Devries A, Braden JB, Sullivan MD. Risks for opioid abuse and dependence among recipients of chronic opioid therapy: results from the TROUP study. Drug Alcohol Depend. Nov 1 2010;112(1-2):90-98.

Saunders KW, Dunn KM, Merrill JO, et al. Relationship of opioid use and dosage levels to fractures in older chronic pain patients. J Gen Intern Med. Apr 2010;25(4):310-315.