SHARE A PATIENT PROVIDER AGREEMENT (PPA) WITH CLEARLY ESTABLISHED BOUNDARIES AND PATIENT EXPECTATIONS PRIOR TO INITIATING A TRIAL OF OPIOIDS FOR CHRONIC NON-CANCER PAIN

A PPA signed by both patient and prescriber and given to the patient is an important, convenient communication tool that can also document patient counseling and education. Offering a PPA to all patients regardless of a patient’s identified risk of opioid misuse and abuse reduces stigma and provides a minimal level of precaution/protection to prescriber and patient. There is no standard, validated or legally binding form of a PPA; consider inclusion of informed consent (e.g., potential risks and benefits of an opioid trial, continuation and discontinuation) and plan of care (e.g., goals of care and expectations, rights and responsibilities of prescriber and patient).

OPTIMIZE PATIENT TREATMENT (DRUG/NON-DRUG) USING A MULTI-DIMENSIONAL RATING SCALE TO ASSESS CHRONIC PAIN, QUALITY OF LIFE AND PROGRESS TOWARD FUNCTIONAL GOALS

The PEG is a brief multi-dimensional measure of Pain, Enjoyment of life and General activity useful at baseline and at regular intervals to assess and document patient response to treatment. Set realistic expectations that full pain relief is unlikely and set individualized goals that are Achievable, Recovery-related, and Measurable (A.R.M.); e.g., 15 minute daily walk. Continue or modify opioid treatment with demonstrated benefit. Discontinue when the risks of side effects, misuse, addiction, and/or overdose outweigh the benefit. Engage family and other key individuals when possible to support patient-obtained information.

SCREEN FOR APPROPRIATE OPIOID USE AND THE CONTINUED NEED FOR OPIOID THERAPY, INCLUDING PRESCRIPTION DRUG MONITORING REPORTS (I.E., SCRIPTS REPORTS)

Assess and document risk of opioid misuse with subjective and objective measures PRIOR to prescribing, and individualize level of monitoring and possible co-management to match the identified risk. Review SCRIPTS reports at baseline and periodically to help identify potential opioid misuse/abuse and support safe prescribing and dispensing. Continue to assess, monitor and document risk of opioid misuse/abuse (including input from family members and key contacts) since risk level can change for any patient at any point. Adjust ongoing monitoring plan (e.g., SCRIPTS report review, frequency of visits, urine drug tests, pill counts) to match risk level, and co-manage or refer for addiction treatment as needed.

Guideline recommendations are largely based on expert consensus, observational or epidemiologic studies, and/or from guidelines. Few studies directly address questions of whether changing practice decreases risk. Given the pressing need to address opioid-related adverse outcomes, guideline developers generally agree on forging recommendations based on relatively weak or indirect evidence now rather than waiting for more rigorous studies.

DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS FOR ABERRANT BEHAVIORS

ADDITION: often characterized by behaviors that may include loss of control regarding drug use, craving, compulsive use and continued use despite harm to health or relationships *Physical dependence and tolerance are normal physiologic adaptations to extended opioid therapy and are not the same as addiction.

PHYSICAL DEPENDENCE: biologic adaptation to a drug that results in abstinence syndrome (signs and symptoms of withdrawal) upon cessation, rapid dose reduction and/or administration of antagonist

TOLERANCE: a physiologic state of reduced effect over time from regular drug exposure in which increased dosage is needed to produce specific effect (increase in dose and no increase in effect may mean opioid is ineffective)

HYPERALGESIA: increase in pain sensitivity that can be seen with rapid opioid dose escalation or high opioid dose (consider if increase in pain with increase in dose)

PSEUDO-ADDICTION: aberrant drug-related behaviors driven by uncontrolled pain (relief seeking vs drug seeking) that are reduced by improved pain control

OTHER PSYCHIATRIC ILLNESSES: anxiety, depression, PTSD, “chemical coping” (knowingly or unknowingly taking medications to decrease or numb negative emotions)

DIVERSION: moving medications from legal/medically indicated users to illegal/unauthorized users
SCRIPTS REPORTS (ALSO CALLED DHEC OR PMP REPORTS) ARE A GOOD TOOL TO CONFIRM A PATIENT’S PRESCRIPTION HISTORY

Do’s and Don’ts Concerning SCRIPTS

- Do use the SCRIPTS report as a tool only. Remember that it is unconfirmed, raw data.
- Do discuss the reports with your patients.
- Do have delegates register and use their own account.
- Do refer a patient to PMP administration (803-896-0688) to request a copy of their own PMP report.
- Do contact the dispenser (pharmacy or dispensing practitioner) to verify information on the SCRIPTS report.
- Don’t query anyone except your own patients.
- Don’t share your account information or password.
- Don’t share reports with other prescribers or pharmacists; instead discuss the report with them if they are involved in the patient’s care.


CONCERNING BEHAVIORS RELATED TO ADDICTION

- Requests for increase in opioid dose
- Requests for specific opioid by name, “brand name only” or allergic to all but the desired opioid
- Overwhelming focus on opioids during visits instead of underlying disease process
- Multiple office contacts regarding opioids
- Unwilling to follow through with recommended therapy/referrals (e.g., physical therapy)
- Running out early due to unsanctioned dose escalation
- Resistance to change therapy despite harm or negative consequences (e.g., over-sedation); unwilling to consider non-opioid therapy
- Concurrent alcohol or substance abuse
- Deterioration in function at home and/or work
- Opposition to monitoring (e.g., pill counts, UDT)
- Three or more requests for early refills
- Multiple “lost”, “spilled”, or “stolen” opioid prescriptions
- Multiple sources for opioids
- Illegal activities – forging prescriptions, selling opioid prescription
- Overdose

Adapted with permission: Boston University SCOPE of Pain Program

**Increased risk of opioid overdose related death has been associated with: 4+ opioid prescribers, 4+ pharmacies, or MEDD > 100 mg.**

<table>
<thead>
<tr>
<th>WHAT IF.......</th>
<th>CONSIDERATIONS</th>
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<tbody>
<tr>
<td>Seemingly good results (1 pharmacy, 1 opioid prescriber)</td>
<td>Does it match clinical evaluations (e.g., urine drug test ([UDT]) and patient interviews?</td>
</tr>
<tr>
<td>No data return * (blank query or report)</td>
<td>Cannot pick up on all non-adherence (e.g., binging, running out early)</td>
</tr>
<tr>
<td>Potential aberrant behavior (2 or more pharmacies, 2 or more opioid prescribers, prescriptions filled that were not reported by patient)</td>
<td>Consider more than one query to accommodate different names (e.g., maiden name and married name)</td>
</tr>
<tr>
<td>Combination of opioid and other controlled substance(s), especially benzodiazepines (consider all)</td>
<td>Contact DHEC SCRIPTS team at 803-896-0688 or email <a href="mailto:scripts@dhec.sc.gov">scripts@dhec.sc.gov</a> for assistance with search</td>
</tr>
<tr>
<td>Opioid-acetaminophen (Opioid/APAP) combination product</td>
<td>Does it match clinical evaluations (e.g., urine drug test ([UDT]) and patient interviews?</td>
</tr>
<tr>
<td>Total morphine equivalent daily dose (MEDD)** (higher dose associated with adverse reactions and overdose)</td>
<td>Consider differential diagnosis, including: addiction (drug seeking), pseudo-addiction (relief seeking), other psychiatric illnesses, or diversion (criminal intent)</td>
</tr>
</tbody>
</table>

Dose among pain guidelines that warrants scrutiny ranges from 80 – 200 mg of morphine equivalents/day

SC Medical Board of Medical Examiners, SC Board of Dentistry and SC Board of Nursing recommend scrutiny if ≥ 80 mg of morphine equivalents/day for more than 3 continuous months

*Not all dispensed opioids require reporting to SCRIPTS, such as methadone dispensed from methadone clinics or <48-hour supply from an emergency department.

**Increased risk of opioid overdose related death has been associated with: 4+ opioid prescribers, 4+ pharmacies, or MEDD > 100 mg.

Adapted from SCORxE materials at the South Carolina College of Pharmacy developed through funding provided by the National Institute on Drug Abuse to Brandeis University.