

# SUMMARY OF ARIZONA OPIOID PRESCRIBING GUIDELINES FOR THE TREATMENT OF CHRONIC NON-TERMINAL PAIN (CNTP)

- #1:** A comprehensive medical and pain related evaluation that includes assessing for substance use, psychiatric comorbidities, and functional status should be performed before initiating opioid treatment for chronic pain.
- #2:** A goal directed trial of opioid therapy is considered appropriate when pain is severe enough to interfere with quality of life and function and the patient has failed to adequately respond to indicated non-opioid and non-drug therapeutic interventions. Potential benefits should be determined to outweigh risks. The patient should agree to participate in other aspects of a pain care plan such as physical therapy and cognitive behavioral therapy when these therapies are recommended and available.
- #3:** The provider should assess for risk of misuse, addiction, or adverse effects, and perform a risk stratification before initiating opioid treatment.
- #4:** Initiating opioids in patients with CNTP should ideally be limited to the evidence-based indication of short term therapy with the purpose of facilitating participation in a comprehensive care plan; however, if chronic opioid therapy (COT) is considered, a goal directed trial lasting 30-90 days should be the starting point. Continuing opioid treatment after the treatment trial should be a deliberate decision that weighs the risks and benefits of chronic opioid treatment for that patient. A second opinion or consult with a pain specialist may be useful.
- #5:** When a trial of opioid therapy is determined to be appropriate, patients should be actively engaged in a process of education, shared decision-making, and informed consent. The provider should obtain and document informed consent including discussion of risks, benefits, and conditions under which opioids are prescribed or discontinued. Documentation of this discussion is ideally accomplished by using a signed Opioid Pain Care Agreement (OPCA).
- #6:** Clinicians treating patients with opioids for chronic pain should obtain and review past records when possible. Ongoing medical records should document the patient evaluation, a treatment plan with clearly defined goals, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant drug-related behavior observed.
- #7:** For patients on chronic opioid therapy (COT), monitoring progress and adherence to the treatment plan is essential to optimize patient care and the overall benefit to risk profile. Appropriate monitoring for COT includes, at a minimum: (1) regular assessment with face to face encounters (2) assessment of response to therapy including assessment of the 6 A's (analgesia, activity, aberrant drug related behaviors, adverse effects, affect, and adjuncts), (3) periodic query of the AZ Controlled Substances Prescription Monitoring Program, and (4) periodic completion of UDT. Frequency of monitoring should be determined by risk category.
- #8:** Clinicians should consider consultation, when available, for patients with: complex pain conditions, serious comorbidities including mental illness, a history or evidence of current drug addiction or abuse, patients who are pregnant or breastfeeding, or when the provider wants help managing the patient.
- #9:** An opioid treatment trial should be tapered/discontinued if the goals are not met and opioid therapy should be tapered/discontinued at any point if risks outweigh benefits or if dangerous or illegal behaviors are demonstrated.
- #10:** COT should be used in the lowest possible doses to achieve treatment goals. Opioid related adverse events increase with doses > 50-100 mg of morphine equivalent dose per day (MEDD) and reaching these doses should trigger a re-evaluation of therapy.
- #11:** Combined use of opioids and benzodiazepines should be avoided if possible. If this combination is used, it should be with great caution and informed consent should be obtained. Particular caution should also be exercised when opioids are used with other sedatives/hypnotics.
- #12:** Methadone should only be prescribed by clinicians who are familiar with its risks and appropriate use and who are prepared to conduct the necessary careful monitoring. Methadone should generally not be prescribed to opioid naïve patients and particular caution should be used if methadone is prescribed for opioid naïve patients.