ARIZONA DEPARTMENT
OF HEALTH SERVICES

THE ARIZONA PAIN AND ADDICTION CURRICULUM

CLINICAL RESOURCE COMPENDIUM

UPDATED 2019

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FOREWORD

This *Resource Compendium* is intended to a be a practical clinical reference for providers who are treating pain and opioid use disorder in the State of Arizona. It includes a range of materials from the standard reference tables of false positives in urine drug screens to Arizona-specific state laws and consultation services.

All resources included in this compendium come from verified, reputable agencies. Some agencies based their materials on other published studies; original sources are included in the notations on each page.

Of note, this *Resource Compendium*, along with the editions of *The Arizona Pain and Addiction Curriculum* and *2018 Arizona Opioid Prescribing Guidelines* are public materials. They are nonproprietary and can be copied and distributed freely.

DISCLAIMER

This document should not be used to establish any standard of care or any deviation or variance from an accepted standard of care; nor should it be used solely to establish any health insurance coverage or determination. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation or variance from any part of this document as evidence of a breach of professional conduct, health insurance coverage policy or determination, or evidence that a deviation or variance from any part of this document demonstrates negligence, misconduct, errors or omissions, or breach of contract in the rendering of health care. This document serves as a clinical resource for providers, meant to promote informed management of Arizonans with pain and addiction. Clinicians should use their own independent clinical judgment and consider but not base clinical decisions solely on this document.

CLINICAL EVALUATION

ARIZONA DEPARTMENT
OF HEALTH SERVICES

PEG SCALE

RESOURCE

PEG, A three-item scale that assesses pain intensity and interference
https://www.naccho.org/uploads/downloadable-resources/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

DESCRIPTION:

The ultra-brief PEG scale has been found to be a reliable and valid measure of chronic pain among primary care patients with musculoskeletal pain and diverse VA ambulatory patients.

HOW TO USE:

Patient can complete this ultrabrief tool before seeing their provider. It can help both providers and patients shift their focus to functional outcomes.

PEG: Scale to Assess Pain Intensity and Interference

▶ **The PEG is a three-item scale to assess pain intensity and interference.**

1. What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely Interferes

Source: Krebs EE, Lorenz KA, Bair MJ, et al. Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. *J. Gen. Intern. Med. 2009;24(6):733-738*

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

FIBROMYALGIA SCREENING TOOL

OPG
OREGON PAIN GUIDANCE

RESOURCE

Fibromyalgia Screening Tool (Widespread Pain Index and Symptom Severity Scale, Pain Catastrophizing Scale)
http://professional.oregonpainguidance.org/wp-content/uploads/sites/2/2017/05/Fibromyalgia_Screening_Tool.pdf

DESCRIPTION:

This is a patient-reported screening tool that includes a widespread pain index (WPI) and severity scale (SS). Based on the number of symptoms checked off along with answers to other diagnostic questions, a formula is then used to determine an accurate fibromyalgia diagnosis.

HOW TO USE:

Patients can complete this screening tool when they have multiple different pain complaints and other distressing symptoms such as fatigue and cognitive symptoms.

A patient meets the diagnostic criteria for fibromyalgia if the following three conditions are met 1) The WPI score is greater than or equal to 7 and the SS score is greater than or equal to 5;

OR

1b. The WPI score (Part 1) is from 3 to 6 AND the SS score (Part 2a & b) is greater than or equal to 9. 2. Symptoms have been present at a similar level for at least 3 months. 3. The patient does not have a disorder that would otherwise explain the pain.

OPG
OREGON PAIN GUIDANCE

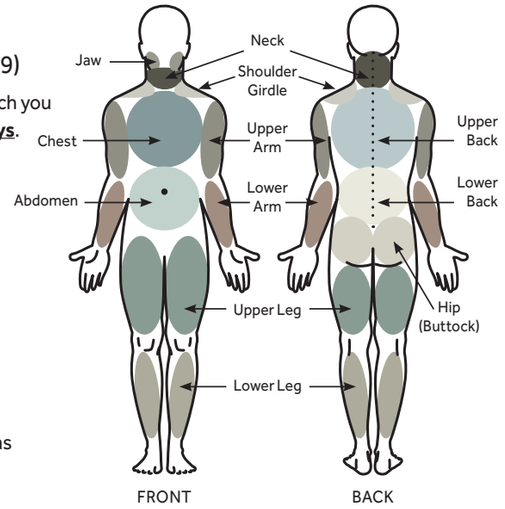
Widespread Pain Index (WPI)

(1 point per check box; score range: 1–19)

Please check the boxes below for each area in which you have had pain or tenderness **during the past 7 days**.

- ☐ Shoulder girdle, left
- ☐ Shoulder girdle, right
- ☐ Upper arm, left
- ☐ Upper arm, right
- ☐ Lower arm, left
- ☐ Lower arm, right
- ☐ Hip (buttock) left
- ☐ Hip (buttock) right
- ☐ Upper leg left
- ☐ Upper leg right
- ☐ Lower leg left
- ☐ Lower leg right
- ☐ Jaw left
- ☐ Jaw right
- ☐ Chest
- ☐ Abdomen
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ None of these areas

WPI score: _____



Symptom Severity (score range: 1–12)

For each symptom listed below, use the following scale to indicate the severity of the symptom **during the past 7 days**.

	No problem	Slight or mild problem	Moderate problem	Severe problem
Points	0	1	2	3
A. Fatigue	☐	☐	☐	☐
B. Trougle thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed	☐	☐	☐	☐

During the **past 6 months** have you had any of the following symptoms?

	Points	0	1
A. Pain or cramps in lower abdomen		☐ No	☐ Yes
B. Depression		☐ No	☐ Yes
C. Headache		☐ No	☐ Yes

SS score: _____

Additional criteria (no score)

Have the symptoms listed on this sheet, and widespread pain been present at a similar level for **at least 3 months**?

☐ No ☐ Yes

TOTAL score: _____

OPG
OREGON PAIN GUIDANCE

PAIN CATASTROPHIZING SCALE

Name_____ Date_____

Age_____ Gender ☐ M ☐ F

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

RATING	0	1	2	3	4
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I am in pain...

	STATEMENT	RATING
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible and I think it's never going to get any better.	
4	It's awful and I feel that it overwhelms me.	
5	I feel I can't stand it anymore.	
6	I become afraid that the pain will get worse.	
7	I keep thinking of other painful events.	
8	I anxiously want the pain to go away.	
9	I can't seem to keep it out of my mind.	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop.	
12	There's nothing I can do to reduce the intensity of the pain.	
13	I wonder whether something serious may happen.	

Source: Sullivan MJL, Bishop S, Pivik J. The pain catastrophizing scale: development and validation. Psychol Assess, 1995, 7:524-532.

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

PRIMARY CARE PTSD SCREEN (PC-PTSD)

RESOURCE

Primary Care PTSD Screen
https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf

DESCRIPTION:

The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5) is a 5-item screen designed to identify individuals with probable PTSD. Those individuals that screen positive require further assessment, preferably with a structured interview.

HOW TO USE:

Physicians can consider screening all patients with chronic pain and addiction for PTSD with this tool.

The measure begins with an item designed to assess whether the respondent has had any exposure to traumatic events. If a respondent denies exposure, the PC-PTSD-5 is complete with a score of 0.

If a respondent indicates a trauma history – experiencing a traumatic event over the course of their life – the respondent is instructed to answer five additional yes/no questions about how that trauma has affected them over the past month.

Preliminary results from validation studies suggest that a cut-point of 3 on the PC-PTSD-5 (e.g., respondent answers “yes” to any 3 of 5 questions about how the traumatic event(s) have affected them over the past month) is optimally sensitive to probable PTSD. Optimizing sensitivity minimizes false negative screen results. Using a cutpoint of 4 is considered optimally efficient. Optimizing efficiency balances false positive and false negative results. As additional research findings on the PC-PTSD-5 are published, updated recommendations for cut-point scores as well as psychometric data will be made available.

Description

The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5) is a 5-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview.

Scoring

The measure begins with an item designed to assess whether the respondent has had any exposure to traumatic events. If a respondent denies exposure, the PC-PTSD-5 is complete with a score of 0.

If a respondent indicates a trauma history – experiencing a traumatic event over the course of their life – the respondent is instructed to answer five additional yes/no questions (see below) about how that trauma has affected them over the past month.

Preliminary results from validation studies suggest that a cut-point of 3 on the PC-PTSD-5 (e.g., respondent answers "yes" to any 3 of 5 questions about how the traumatic event(s) have affected them over the past month) is optimally sensitive to probable PTSD. Optimizing sensitivity minimizes false negative screen results. Using a cut-point of 4 is considered optimally efficient. Optimizing efficiency balances false positive and false negative results. As additional research findings on the PC-PTSD-5 are published, updated recommendations for cut-point scores as well as psychometric data will be made available.

Example

In the past month, have you ...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?	YES	NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
3. been constantly on guard, watchful, or easily startled?	YES	NO
4. felt numb or detached from people, activities, or your surroundings?	YES	NO
5. felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused?	YES	NO
Total score is sum of "YES" responses in items 1-5.	**TOTAL SCORE**	

ID # _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

   YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

   YES NO

3. been constantly on guard, watchful, or easily startled?

   YES NO

4. felt numb or detached from people, activities, or your surroundings?

   YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

   YES NO

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

SCREENING FOR DEPRESSION

RESOURCE

Patient Health Questionnaire (PHQ-9)
https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218

DESCRIPTION:

The Patient Health Questionnaire (PHQ-9) is an instrument used for screening, diagnosing, monitoring and measuring the severity of depression. It incorporates the *DSM* depression diagnostic criteria with other major depressive symptoms into a brief self-report tool.

HOW TO USE:

Physicians should follow the U.S. Preventive Services Task Force recommendations for screening individuals for depression. The PHQ-9 is brief and useful in clinical practice. It is completed by the patient and is rapidly scored by the clinician.

Recommendation Summary

Population	Recommendation	Grade (What's This?)
General adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

SCREENING FOR GENERALIZED ANXIETY DISORDER

SAMHSA
Substance Abuse and Mental Health Services Administration

RESOURCE

Generalized Anxiety Disorder Seven-Item Scale (GAD-7)
https://www.integration.samhsa.gov/clinical-practice/screening-tools#anxiety

DESCRIPTION:

The Generalized Anxiety Disorder Seven-Item Scale (GAD-7) asks patients over the previous two weeks, how often they have been bothered by feeling nervous, worrying too much, etc. Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD.

HOW TO USE:

Clinicians may consider screening for anxiety in conjunction with screening for depression because of the frequent co-occurrence of anxiety and depressive disorders. There is no specific USPSTF recommendation on screening, although it notes in the Recommendation for Depression Screening: "All positive [depression] screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems (e.g. anxiety, panic attacks, or substance use)..." ACOG and AAFP have noted that screening should ideally be implemented with other efforts to ensure diagnosis and treatment.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

SCREENING FOR TOBACCO USE

RESOURCE

AAFP "Ask and Act" – Tobacco Cessation Program
https://www.aafp.org/patient-care/public-health/tobacco-nicotine/ask-act.html

DESCRIPTION:

The AAFP Tobacco Cessation Program "Ask and Act" is an evidence-based strategy based on USPHS recommendations for brief interventions for patients who smoke. It encourages family physicians to ASK all patients about tobacco use, then to ACT to help them quit. Included on the website is a pharmacologic product guide, guide to tobacco cessation group visits, and how to create a template to ensure tobacco exposure is addressed with patients and treatment is adequately documented.

HOW TO USE:

Physicians should follow the U.S. Preventive Services Task Force recommendations for screening adults for tobacco use.

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults who are not pregnant	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A
Pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A
Pregnant women	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women.	I
All adults, including pregnant women	The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety (previously stated).	I

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

SCREENING FOR UNHEALTHY ALCOHOL USE

National Institute on Drug Abuse
Advancing Addiction Science

RESOURCE

NIDA's AUDIT – Alcohol Use Disorders Identification Test
https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf

DESCRIPTION:

The AUDIT is a 10-item validated screening tool developed by the WHO to assess alcohol consumption, drinking behaviors, and alcohol-related problems. The AUDIT has been found to have good sensitivity and specificity across multiple populations. There are two versions included here: a clinician-administered version and self-report version.

HOW TO USE:

Physicians should follow the U.S. Preventive Services Task Force recommendation for screening individuals for unhealthy alcohol use. If using the AUDIT tool, a score of 8 or more is considered to indicate hazardous or harmful alcohol use.

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B
Adolescents aged 12 to 17 years	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. See the Clinical Considerations section for suggestions for practice regarding the I statement.	I

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

CLINICAL TOOLS FOR WHOLE-PERSON ASSESSMENT

WITHDRAWAL ASSESSMENT TOOL FOR ALCOHOL

University of Maryland School of Medicine

RESOURCE

Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar)
umem.org/files/uploads/1104212257_CIWA-Ar.pdf

DESCRIPTION:

This is an assessment for monitoring symptoms of alcohol withdrawal that requires approximately five minutes to administer to a patient. There is a mix of questions and clinical observations.

HOW TO USE:

This tool can be used to more objectively determine the severity of alcohol withdrawal and has well-documented reliability, validity, and reproducibility. The tool can be used to triage patients who are experiencing alcohol withdrawal to determine the most appropriate treatment setting (inpatient vs outpatient) and also as a guide for medication dosing when treating alcohol withdrawal.

Scoring is as follows: ≤ 10 = mild withdrawal; 11-15 = moderate withdrawal; > 15 = severe withdrawal.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

*The **CIWA-Ar** is not* copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

CLINICAL TOOLS FOR OPIOID USE DISORDER

WITHDRAWAL ASSESSMENT TOOL FOR OPIOIDS

National Institute on Drug Abuse
Advancing Addiction Science

RESOURCE

Clinical Opiate Withdrawal Scale (COWS)
https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

DESCRIPTION:

This is an 11-item scale designed to be administered by a clinician in inpatient and outpatient settings to reproducibly rate common signs and symptoms of opioid withdrawal. The summed score for the complete scale can be used to help clinicians determine the stage or severity of withdrawal and assess the level of physical dependence on opioids.

HOW TO USE:

This tool can be used as a more objective measurement of opioid withdrawal severity and is useful whenever evaluating opioid withdrawal, and particularly when determining the appropriate timing for buprenorphine induction. Scoring is as the following: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe withdrawal.

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs,* 35(2), 253–9.

(1) NIH National Institute on Drug Abuse
Advancing Addiction Science

RESOURCE

NIDA Quick Screen
drugabuse.gov/nmassist
https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

DESCRIPTION:

The NIDA Quick Screen is a screening tool that helps identify risky substance use (including opioid use) in adult patients. It includes asking the patient how many times, within the past year, has he or she used any of the substances (alcohol, tobacco, prescription drugs, illegal drugs). If the patient says "Never" to all substances, the clinician should reinforce abstinence, and screening is complete. There are other recommendations if the patient says "Yes" to Alcohol or Tobacco, but if the patient says "Yes" for use of illegal or prescription drugs for nonmedical reasons, the clinician should move onto a second screen (the eight questions included at website above).

HOW TO USE:

Clinicians can consider using the two-part NIDA Quick Screen for all patients in primary care, and particularly those with pain and any substance use disorder.

A member of the healthcare team can administer the screening tool to the patient. After completing the questionnaire, the screening tool will show how to tally the responses and generate a substance involvement score, determine risk and recommended level of intervention, and provide additional resources. Clinicians should make sure to develop office procedures for how positive and negative results will be handled.

> For example: "Deal with severe, immediately life-threatening medical consequences of substance abuse as you would any other medical emergency. If same day substance abuse treatment assessment is not available, transfer patient to the emergency room. Arrange alternative transportation for patients under the influence of drugs, alcohol, or medication that would impair their driving."

Clinicians should be aware of the U.S. Preventive Services Task Force recommendations for screening for illicit drug use. The draft recommendation (at the time of this Compendium publication) recommends screening in adults over 18 years old.

Draft: Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults age 18 years or older	The USPSTF recommends screening for illicit drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.	B
Adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for illicit drug use in adolescents. See the Practice Considerations for suggestions for practice regarding the I statement.	I

Return to Table of Contents

NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/ activities/assist_v3_english.pdf).*

CLINICAL TOOLS FOR OPIOID USE DISORDER

SCREENING FOR UNHEALTHY SUBSTANCE USE (3)

(2) NIH National Institute on Drug Abuse *Advancing Addiction Science*

RESOURCE

Tobacco, Alcohol, Prescription Medication, and Other Substance Use Tool (TAPS)
drugabuse.gov/taps/#/
https://cde.drugabuse.gov/sites/nida_cde/files/TAPS%20Tool%20Parts%20I%20and%20II%20V2.pdf

DESCRIPTION:

This screening tool consists of a combined screening component (TAPS-1, a 4-item screen for tobacco, alcohol, illicit drugs and nonmedical use of prescription drugs) followed by a brief assessment (TAPS-2, brief substance-specific assessment questions to arrive at a risk level) for those that screen positive. Like the NIDA Quick Screen, it is combines screening and brief assessments for commonly used substances, eliminating the need for multiple screens. It has been validated in primary care settings for identifying adults with and without problem use or substance use disorders.

HOW TO USE:

Physicians can consider using the TAPS screening tool for all patients in primary care. This tool takes five minutes to complete, and may be completed either self-administered by the patient or as an interview by a member of the healthcare team. Upon completion, the tool will automatically generate a risk level for each substance class. Implications of the score, along with suggested clinician actions and additional resources, are also provided.

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

   c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No
   d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No
   b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No
If "Yes", answer the following questions:
   a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ☐ Yes ☐ No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ☐ Yes ☐ No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)? ☐ Yes ☐ No

If "Yes", answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

Comments:

CLINICAL TOOLS FOR OPIOID USE DISORDER

SCREENING FOR UNHEALTHY SUBSTANCE USE (3)

(3) Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

RESOURCE

CRAAFT Screening Tool
https://brightfutures.aap.org/Bright%20Futures%20Documents/Screening.pdf

DESCRIPTION:

This CRAAFT screening tool has high sensitivity and specificity for identifying a diagnosis of unhealthy substance use in adolescents.

HOW TO USE:

A positive CRAFFT should be followed by a more comprehensive alcohol and drug use history, including age of first use, current pattern of use, impact on physical and emotional health, school, and family, and other negative consequences from use.

The U.S. Preventative Services Task Force recommendations are that screening for illicit drug use in adolescents is a Grade I (Insufficient evidence). However the American Academy of Pediatrics recommends that substance use should be evaluated as part of an age-appropriate comprehensive history.

Box 1. The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use *anything else* to *get high*? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions in Part B**

Part B

	No	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

CLINICAL EVALUATION

PERSONAL HEALTH INVENTORY TOOL (PHI)

RESOURCE

Personal Health Inventory Tool
https://www.va.gov/WHOLEHEALTH/docs/PHP-WalletCard-508-WHFL-fillable-IB10931-P96815.pdf
https://www.va.gov/PATIENTCENTEREDCARE/docs/Personal-Health-Inventory-final-508-WHFL.pdf

DESCRIPTION:

This Personal Health Inventory Tool helps both patients and providers shift from a focus on pain and disease to identifying the patient's values and selecting specific positive health goals. It captures where patients are and where they would like to be in the multiple domains of their overall health and well-being. There is a 2-page version shown below and an 11-page workbook listed above; the 2-page version is more likely to be used in primary care.

HOW TO USE:

This 2-page form (or 11-page workbook) can be briefly introduced to all patients, sent home with patients as "homework" and then discussed with a member of the healthcare team to create a collaborative care plan and functional life goals.

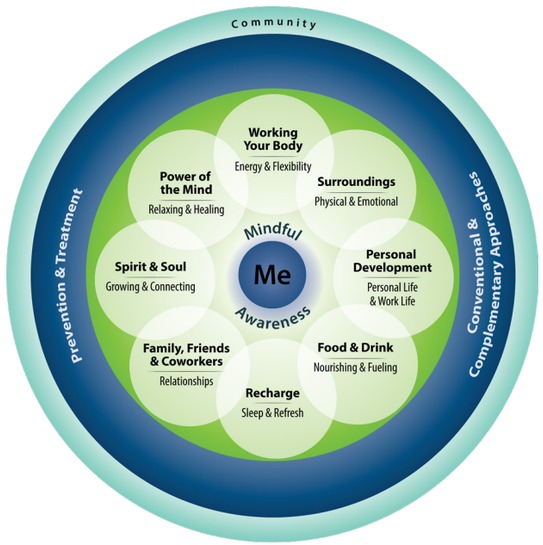
U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Patient Centered Care and Cultural Transformation

Whole Health for Life

My Personal Health Plan Wallet Card

Whole Health is all about helping me live my life to the fullest.

My Mission, Aspiration or Purpose: What do I live for? What matters most to me?



Areas of strength (+), challenge (-)
My areas of focus are checked

+ or -	Area of Circle	✓
	Mindful Awareness	
	Working My Body	
	Surroundings	
	Personal Development	
	Food and Drink	
	Recharge	
	Family, Friends and Coworkers	
	Spirit and Soul	
	Power of the Mind	
	Professional Care	
	Community	

Why do I want to be healthy? How does being healthy support what matters most to me?

IB 10-931

P96815

My overall goals:

My self-care priorities:

Major medical concerns and screenings:

Medications and supplements:

Professional care (conventional and complementary):

My support team (family, friends, health team members):

My education and skill building:

Revised 7/18

https://www.va.gov/patientcenteredcare/

URINE DRUG SCREENS

ARIZONA DEPARTMENT
OF HEALTH SERVICES

URINE DRUG SCREENS

GUIDANCE + REFERENCE TABLES

RESOURCE

Toolkit: CDC Guidance on Urine Drug Testing
https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

Quick Reference Guide: Opioid Safety, VA Academic Detailing Service

Table 11: Windows of Detection for Drugs of Abuse; *The Arizona Pain and Addiction Curriculum (UME Edition)*
https://azdhs.gov/documents/audiences/clinicians/curriculum/arizona-pain-addiction-faculty-guide.pdf

DESCRIPTION:

There are several tools and references included in this section.

The CDC toolkit is part of their guidance for "Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain." It includes key points to discuss with patients before and after conducting urine drug tests.

The selections from the VA Academic Detailing's Quick Reference Guide include tables of test methods, agents potentially contributing to false positives, and interpretation of drug testing.

Table 11 comes from *The Arizona Curriculum for Pain for Addiction, UME Edition*. It details the windows of detection for drugs of abuse.

HOW TO USE:

All patients on long-term opioid therapy should have urine drug tests at regular intervals determined by risk (e.g. every 3 months). Regular and random urine drug screening should be a standard clinical policy.

Toolkit Part I.

Additional Guidance on Urine Drug Testing

Who should be tested?

All patients on long-term opioid therapy should have UDTs periodically. Patients can be targeted for testing based on the risk of abuse or be selected randomly, though implementing random testing can be difficult for practices. [4-11] Universal testing similar to universal precautions is another approach that aims to "de-stigmatize" testing and to remove any perceived bias related to patients selected for testing. [1-4, 6-7, 13-16]

Key points to provide patients before conducting UDT

▶ **Discuss the following key points regarding UDT with the patient beforehand:**

- Purposes of testing.
- Provider/patient trust—requiring UDT does not imply a lack of trust on the part of the provider; it is part of a standardized set of safety measures.
- What drugs the test will cover.
- What results does the patient expect?
- Prescribed drugs or any other drugs (including marijuana and other illicit drugs) the patient has taken.
- Time and dose of most recently consumed opioids.
- Potential cost to patient if the UDT is not covered by insurance.
- Expectation of random repeat testing depending on treatment agreement and monitoring approach.
- Actions that may be taken based on the results of the test.

Interpreting results and actions to be taken

Providers need to be aware of the limits of UDTs and have a resource for questions regarding drug testing or results.[12] This could be a certified medical review officer, clinical laboratory director, or manufacturer for point of care (POC) testing.[10] Multiple variables affect the diagnostic accuracy of UDTs, including cutoff selection, pharmacokinetics, pharmacodynamics, and pharmacogenetics, laboratory technology, and subversion or adulteration of the urine specimen. [3-4, 16]

[1] Chou R. 2009 Clinical Guidelines from the American Pain Society and the American Academy of Pain Medicine on the use of chronic opioid therapy in chronic noncancer pain: what are the key messages for clinical practice? Pol Arch Med Wewn. 2009;119(7-8):469-477

[2] Chou R, Deyo R, Devine B, et al. The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain. Vol Evidence Report/Technology Assessment No. 218. Rockville, MD: Agency for Healthcare Research and Quality; 2014.

[3] Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 1 - Evidence assessment. Pain Physician. 2012;15:S1-S66.

[4] Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2 - Guidance. Pain Physician. 2012;15:S67-S116.

[5] National Opioid Use Guideline Group (NOUGG). Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. 2010.

[6] Chou R, Fanciullo GJ, Fine PG, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. J Pain. 2009;10(2):113-130.

[7] Hooten WM, Timming R, Belgrade M, et al. Institute for Clinical Systems Improvement. Assessment and Management of Chronic Pain. 2013.

[8] Thorson D, Biewen P, Bonte B, et al. Institute for Clinical Systems Improvement. Acute Pain Assessment and Opioid Prescribing Protocol. 2014.

[9] The University of Michigan. Managing Chronic Non-Terminal Pain Including Prescribed Controlled Substances. Guidelines for Clinical Care. 2009.

[10] Department of Veterans Affairs, Department of Defense. VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The Management of Opioid Therapy for Chronic Pain Working Group. 2010.

[11] Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain 2015.

[12] Agency Medical Directors Group (AMDG). Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain: An educational aid to improve care and safety with opioid therapy. 2010.

[13] Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert ASB. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. 2015;350.

[14] Degenhardt L, Bruno R, Lintzeris N, et al. Agreement between definitions of pharmaceutical opioid use disorders and dependence in people taking opioids for chronic non-cancer pain (POINT): a cohort study. Lancet Psychiatry. 2015;2(4):314-322.

[15] Timm KE. A randomized-control study of active and passive treatments for chronic low back pain following L5 laminectomy. Journal of Orthopaedic & Sports Physical Therapy. 1994;20(6):276-286.

[16] Christo PJ, Manchikanti L, Ruan X, et al. Urine drug testing in chronic pain. Pain Physician. 2011;14:123-143.

Unexpected UDT results, interpretation, and options for providers' response

▶ **Table 3. Unexpected results, possible explanations, and potential actions for providers to take**

Unexpected result	Possible explanation	Actions for provider
UDT negative for prescribed opioid	• False negative. • Non-compliance. • Diversion.	• Repeat test using chromatography: specify the drug of interest (e.g., oxycodone often missed by immunoassay). • Take detailed history of the patient's medication use for the preceding 7 days (e.g., could learn that patient ran out several days prior to test). • Ask patient if they've given the drug to others. • Monitor compliance with pill counts.
UDT positive for non-prescribed opioid or benzodiazepines	• False positive. • Patient acquired opioids from other sources (double doctoring, "street").	• Repeat UDT regularly • Ask the patient if they accessed opioids from other sources. • Assess for opioid misuse/addition? • Review/revise treatment agreement.
UDT positive for illicit drugs (e.g., cocaine, cannabis)	• False positive. • Patient is occasional user or addicted to the illicit drug. • Cannabis is positive for patients taking dronabinol (Marinol). THC: CBD (Sativex) or using medical marijuana.	• Repeat UDT regularly. • Assess for abuse/addiction and refer for addiction treatment as appropriate. • Ask about medical prescription of dronabinol, Delata-9-Tetrahydrocannabinol (THC): Cannabidiol (CBD) or medical marijuana access program.
Urine creatinine is lower than 2-3 mmol/liter or < 20 mg/dL	• Patient added water to sample.	• Repeat UDT. • Consider supervised collection or temperature testing. • Take a detailed history of the patient's medication use for the preceding 7 days. • Review/revise treatment agreement.
Urine sample is cold	• Delay in handling sample (urine cools within minutes). • Patient added water to sample.	• Repeat UDT. • Consider supervised collection or temperature testing. • Take a detailed history of the patient's medication use for the preceding 7 days. • Review/revise treatment agreement.

Source: National Opioid Use Guideline Group (NOUGG). Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. 2010.

Actions to take after UDT results

▶ **Act on the UDT results in the following ways:**

- Inform the patient of the test results.
- Discuss with the patient any unexpected results or findings of drug use that the patient had talked about prior to the test. It can be helpful to ask patients what to expect the UDT will show beforehand.
- Review the treatment agreement and reiterate concerns about the patient's safety.
- Determine if frequency and intensity of monitoring should be increased.

For additional information on using UDTs to monitor opioid therapy, see the Washington State Agency Medical Directors' Group's Interagency Guidelines on Prescribing Opioids for Pain. (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).

Urine Drug Testing Methods[3-5]

Type of Test	Logistics	Pearls
Initial Screening Test: Immunoassay	• Inexpensive • Fast • Widely available	• High sensitivity, low specificity (higher potential for false positives) • Opiate screen not sensitive for semisynthetic (e.g. oxycodone) or synthetic opioids (e.g. fentanyl)
Confirmatory Test: Gas chromatography-mass spectrometry (GCMS)[+] or Liquid chromatography-mass spectrometry (LCMS)	• Expensive • Time consuming	• High sensitivity, high specificity • Expensive • Detects medication even if concentration is low

[+] GCMS is considered the criterion standard for confirmatory testing; Immunoassay tests have high predictive values for marijuana and cocaine, but lower predictive values for opiates and amphetamines

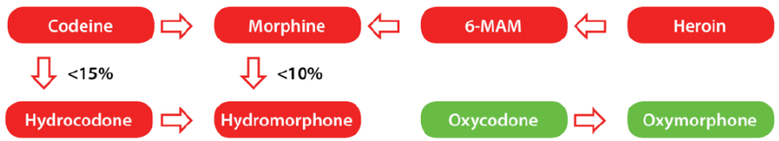
Urine Drug Testing Specimen Validity[3-4]	Normal Characteristics of a Urine Sample[3-5]
• Urine samples that are adulterated, substituted, or diluted may avoid detection of drug use[4] • Urine collected in the early morning is most concentrated and most reliable • Excessive water intake and diuretic use can lead to diluted urine samples (Creatinine < 20) [3-4] • THC assays are sensitive to adulterants (e.g. Visine eyedrops)	Temperature within 4 minutes of voiding: 90-100°F pH: 4.5-8.0 Creatinine: > 20 mg/dL Specific gravity: > 1.003 Nitrates: < 500 mcg/dL Volume: ≥ 30 mL

Agent	Summary of Agents Potentially Contributing to False Positives[3-8]
Marijuana metabolites	• dronabinol • efavirenz • NSAIDs* • proton pump inhibitors • hemp foods: tea, oil[+]
Cocaine metabolites	• coca leaf teas • topical anesthetics containing cocaine
Opioid metabolites	• dextromethorphan • flouroquinolones • levofloxacin • ofloxacin • poppy seeds • poppy oil • rifampin • quinine
Amphetamines/ Methamphetamine (high rate of false positives)	• amantadine • benzphetamine • brompheniramine • bupropion • chlorpromazine • desipramine • dextroamphetamine • doxepin • ephedrine • fluoxetine • isometheptene • isoxsuprine • labetalol • l-methamphetamine (OTC nasal inhaler) • methylphenidate • MDMA • phentermine • phenylephrine • phenyl-propanolamine • promethazine • pseudoephedrine • ranitidine • selegiline • thioridazine • trazodone • trimethobenzamide • trimipramine
Benzodiazepines	• oxaprozin • sertraline
Barbiturates	• ibuprofen • naproxen
Methadone	• chlorpromazine • clomipramine • diphenhydramine • doxylamine • ibuprofen • quetiapine • thioridazine • verapamil
Alcohol	• mouthwash • short-chain alcohols • OTC cough products (isopropyl alcohol)

* NSAIDs resulting in false-positive for marijuana mainly consist of ibuprofen and naproxen and modern tests **do not** result in false positives ; [+] THC concentrations in hemp products are low enough to prevent positive immunoassay results

Interpreting Urine Drug Testing[2,3-5]

Drug or Class	Expected Results	Considerations
Alcohol	Alcohol	• Testing for ETOH metabolites, ethyl glucuronide or ethyl sulfate, can identify alcohol up to 80 hours after consumption
Amphetamines	**Immunoassay**–amphetamines, methamphetamines or MDMA **Confirmatory**–amphetamines, methamphetamines or MDMA	• Immunoassay tests are highly cross-reactive; therefore confirmatory testing is required and can identify which amphetamine is present
Benzodiazepines	**Immunoassay**–unconjugated oxazepam or its metabolites **Confirmatory**–alprazolam, diazepam, clonazepam, lorazepam, etc.	• Immunoassays for benzodiazepines have a 28% overall false negative rate • Confirmatory testing is needed when use is expected or suspected (alprazolam, clonazepam and lorazepam often not detected by immunoassay)
Barbiturates	**Immunoassay**–barbiturates	• N/A
Cocaine metabolites	**Immunoassay**–cocaine or benzoylecgonine (BEG)	• Cocaine's primary metabolite, BEG, has low cross-reactivity with other substances and is highly predictive of cocaine use • A positive result should be interpreted as recent exposure to cocaine

Interpreting Urine Drug Testing[2,3-5]		
Drug or Class	**Expected Results**	**Considerations**
Opioids or "opiates"- Natural (from opium)		
Codeine (Tylenol # 2,3,4)	**Opiates Immunoassay**–positive **Confirmatory**–codeine, possibly morphine & hydrocodone	• Immunoassays for "opiates" are responsive to morphine and codeine but do not distinguish which • Codeine is metabolized to morphine and small quantities of hydrocodone
Morphine (Avinza, Embeda, MS Contin, Kadian)	**Opiates Immunoassay**–positive **Confirmatory**–morphine, possibly hydromorphone	• Immunoassays for "opiates" are responsive to morphine and codeine but do not distinguish which • Morphine (<10%) may be metabolized to hydromorphone
Heroin	**Opiates Immunoassay**–positive **Confirmatory**–heroin (6-MAM), morphine, possibly codeine	• 6-MAM is pathognomic for heroin use, detection 12–24 hrs • Heroin is metabolized to morphine
Opioid Metabolic Pathways		

Interpreting Urine Drug Testing[2,3-5]		
Drug or Class	**Expected Results**	**Considerations**
Opioids-Semisynthetic (derived from opium)		
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)	**Opiates Immunoassay**–positive **Confirmatory**–hydrocodone, possibly hydromorphone	• "Opiates" immunoassay may detect semisynthetic opioids º hydrocodone > hydromorphone > oxycodone • Negative result does not exclude use and confirmatory testing (GC/MS) is required • Hydrocodone is metabolized in small amounts to hydromorphone, both may be found in urine • Oxycodone is metabolized to oxymorphone, both may be found in urine • Hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively
Hydromorphone (Dilaudid, Exalgo)	**Opiates Immunoassay**–may be positive **Confirmatory**–hydromorphone	
Oxycodone (Roxicet, OxyCotonin)	**Opiates Immunoassay**–may be positive **Oxycodone Immunoassay**–positive **Confirmatory**–oxycodone possibly oxymorphone	
Oxymorphone (Opana)	**Oxycodone Immunoassay**–positive **Confirmatory**–oxymorphone	
Opioids-Synthetic (man-made)		
Fentanyl	**GC/MS**–fentanyl and norfentanyl	• Current "opiates" immunoassays do not detect synthetic opioids • Confirmatory testing (GC/MS) is needed
Meperidine (Demerol)	**GC/MS**–normeperidine, possibly meperidine	
Methadone (Methadose)	**Methadone Immunoassay**–positive **GC/MS**–methadone, EDDP	
Propoxyphene (Darvon, Darvocet)	**Propoxyphene Immunoassay**–positive **GC/MS**–propoxyphene & norpropoxyphene	

Confirmatory testing: Chromatography (gas chromatography-mass spectrometry (GC/MS) or liquid chromatography-mass spectrometry (LC/MS)) Note: Each facility may have its own order sets and lab policies and procedures. Contact your lab for additional details.

TABLE 11: WINDOWS OF DETECTION FOR DRUGS OF ABUSE ADAPTED FROM ASAM'S APPROPRIATE USE OF DRUG TESTING IN CLINICAL ADDICTION MEDICINE (2017)[424]

DRUG	DETECTION TIME IN URINE
Amphetamine or Methamphetamine	1-3 days
Barbiturates	Short-acting barbiturates: 1-4 days Long-acting barbiturates: 30 days
Cocaine metabolite benzoylecgonine	1-3 days
Ethyl glucuronide (alcohol metabolite)	2-6 days
Heroin	Heroin metabolizes to 6-monoacetylmorphine (6-MAM) which is specific to heroin, is only present for about 6 hours and therefore of limited clinical utility. 6-MAM is subsequently metabolized to morphine which has a window of detection of 1-3 days in the urine and will result in a positive result on an opiate immunoassay screen.
Marijuana*	Occasional Use: 1-3 days Chronic Use: 30 days
Methadone	2-10 days
Morphine	1-3 days
Phenycycline (PCP)	Occasional Use: 2-7 days Chronic Use: 30 days

*Passive exposure to marijuana will not produce false positive urine drug screen.

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ABUSE-DETERRENT FORMULATIONS

ARIZONA DEPARTMENT OF HEALTH SERVICES

FDA U.S. FOOD & DRUG ADMINISTRATION

RESOURCE

Abuse-Deterrent Drugs, Summary Table

DESCRIPTION:

The development and marketing of new formulations of opioids were factors in the development of the current U.S. opioid epidemic.

There are currently newer formulations of opioids that now exist and are being marketed to prescribers. There is a new focus on abuse-deterrent formulations (ADF), or opioids that are designed to prevent altered routes of administration. Clinicians should maintain academic skepticism as:

1. Abuse-deterrent formulations are not abuse-proof or addiction-proof.

2. Current abuse-deterrent formulations are long-acting with higher opioid dosage options per pill, potentially leading to higher dose opioid therapy and greater risk of development of addiction and overdose.

3. There is a lack of clear evidence that abuse-deterrent formulations are safer than non-abuse deterrent formulations.

There are two examples of formulations being removed from the market, due to the points above:

1. Opana® ER (long acting oxymorphone) was originally approved in 2006, and a reformulation intended to be abuse-deterrent was approved in 2011. Recognizing safety concerns and abuse patterns, the FDA requested that the manufacturer voluntarily withdraw the reformulated product, which the manufacturer did the following month.

2. OxyContin® was first approved in 1995 and was marketed as a safer and less addictive opioid. The first Oxycontin formulation increased the maximum amount of oxycodone in single pill (from 30mg in oxycodone IR) to 160mg in the highest strength OxyContin® pill. This formulation was a key factor in the development of the opioid epidemic and the manufacturer, Purdue Pharma, plead guilty to criminal charges in 2007 for misleading the public about its addiction risk. In 2010, an abuse-deterrent formulation of OxyContin® was released and while causal evidence is lacking, there is concern that this reformulation contributed to an increase in heroin use and overdose mortality from heroin.

HOW TO USE:

The clinician who is concerned about abuse from a patient's use of opioids should reconsider prescribing an opioid or should consider utilizing an exit strategy.

The clinician should also consider the source when recommendations for these treatments appears in guidelines, representatives and lectures.

Up-to-date information can also be found at the FDA website https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/abuse-deterrent-opioid-analgesics.

For clinician awareness, the following is a summary table of the newer abuse-deterrent formulations available.

Trade Name	Drug Name	Manufacturer
OxyContin® ER	oxycodone extended release	Purdue Pharma L.P.
Xtampza® ER	oxycodone extended release	Purdue Pharma L.P. / Collegium Pharmaceutical, Inc.
Hysingla® ER	hydrocodone extended release	Purdue Pharma L.P.
Embeda®	morphine and naltrexone extended release	Pfizer, Inc.
MorphaBond™ ER	morphine extended release	Daiichi-Sankyo

OPIOID + BENZODIAZEPINE PHARMACOLOGY

OPIOID EQUIVALENCE TABLE AND CALCULATOR

RESOURCE

Opioid Equivalence Table
https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Opioid Conversion Calculator
https://www.oregonpainguidance.org/opioidmedcalculator/

DESCRIPTION:

Online calculators or opioid equivalence tables can help provide an assessment of the total opioid dose a patient is receiving and can guide the risk assessment and risk mitigation intensity.

HOW TO USE:

Caution: There is significant inter-individual variation and opioid equivalence calculations should be used with caution when switching between opioids. If switching between opioids, the new opioid dose should be lowered (by 33-50%) to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics.

Caution: Use caution when conversions involve methadone or fentanyl. Consult the package inserts for conversion assistance.

HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

1. **DETERMINE** the total daily amount of each opioid the patient takes.
2. **CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor. (*see table*)
3. **ADD** them together.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	**CONVERSION FACTOR**
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

BENZODIAZEPINE EQUIVALENCE TABLE

RESOURCE

Benzodiazepine Equivalence Table
http://www.cpsa.ca/wp-content/uploads/2017/06/Benzodiazepine-Clinical-Toolkit-Use-and-Taper.pdf

DESCRIPTION:

This is a trustworthy source for benzodiazepine equivalence (uncertain equivalency is marked with double asterisk).

HOW TO USE:

This is useful for outpatient benzodiazepine tapering or changes in dosage (see included resources on Benzodiazepine Tapering). As noted above, equivalences are approximate, and careful monitoring is required to avoid over-sedation.

Benzodiazepine	Equivalent to 5 mg diazepam (mg) *
Alprazolam (Xanax®)**	0.5
Bromazepam (Lectopam®)	3–6
Chlordiazepoxide (Librium®)	10–25
Clonazepam (Rivotril®)	0.5–1
Clorazepate (Tranxene®)	7.5
Flurazepam (Dalmane®)	15
Lorazepam (Ativan®)	0.5–1
Nitrazepam (Mogadon®)	5–10
Oxazepam (Serax®)	15
Temazepam (Restoril®)	10–15
Triazolam (Halcion®)**	0.25

* Equivalences are approximate. Careful monitoring is required to avoid over-sedation, particularly in older adults and those with impaired hepatic metabolism.
**Equivalency uncertain.

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HOW TO APPROACH AN "INHERITED" PATIENT TAKING OPIOID THERAPY

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RESOURCE

Appendix B: How to Approach an 'Inherited' Patient on Opioid Therapy, *2018 Arizona Opioid Prescribing Guidelines*
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribingguidelines/az-opioid-prescribing-guidelines.pdf

DESCRIPTION:

This appendix comes from a forward thinking, evidence-based set of opioid prescribing guidelines.

Appendix B of these guidelines is "How to approach an 'inherited' patient on opioid therapy." It employs a checklist of actions to take before the clinical visit, during the initial visit and after the visit.

HOW TO USE:

The guidance for "before the visit" can be used to influence clinical policy. The entire Appendix is a resource that will particularly be helpful when primary care providers are managing the care of new patients who have been discharged from another practice and from a clinician's care.

APPENDIX B: HOW TO MANAGE AN "INHERITED PATIENT" ON OPIOID THERAPY

Establishing care of new patients on long-term opioid therapy can be difficult, but it is an opportunity to optimize the treatment approach. The following is a guide to how to approach these situations, based on the following concepts:

- Safety is always more important than immediate pain relief.
- Care of the patient's pain and distress is imperative; care does not necessarily include opioids.
- Assessment and management of substance use disorders is important.
- Opioid withdrawal can be very uncomfortable and distressing, but it is rarely a medical emergency.
- Opioid withdrawal can be effectively managed with both pharmacologic and non-pharmacologic approaches.

NOTE: A patient in pain or with opioid use disorder, faced with changes in their treatment regimen, can become stressed. It is imperative that providers have empathy and compassion, and that they do not treat these new patients as problematic. The provider's approach can impact whether the person receives evidence-based treatment for chronic pain and/or addiction relief and whether the person turns to illicit sources and/or has a worsening of their psychological comorbidities.

BEFORE THE VISIT

- Consider establishing a clinic policy that a patient's first visit will serve as an assessment, which includes review of prior medical records and patient examination. It does not involve prescribing of controlled substances.
  - Sample policy: med.umich.edu/1info/FHP/practiceguides/pain/policy.pdf
- Contact new patients prior to their first visit to review clinic policies and what to expect at their first clinical visit, including the request to bring in all previous medical records and current medications.
- Verify that clinical providers and staff representatives have access to the Arizona Controlled Substances Prescription Monitoring Program. The requirement to check the CSPMP is mandated under §A.R.S. 36-2606.
  - CSPMP application: *arizona.pmpaware.net/login*
- Consider becoming a medication assisted treatment provider, to broaden the therapeutic options for patients at their primary facility
  - See Buprenorphine Waiver Training: samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

DURING THE INITIAL VISIT

- Complete a comprehensive Biopsychosocial Assessment of the patient.
  - Elements of the biopsychosocial pain interview include a pain-related history, assessment of pertinent medical and psychiatric comorbidities including personal and family history of substance use disorder, assessment of withdrawal symptoms, functional status and functional goals, coping strategies, and psychosocial factors such as the patient's beliefs and expectations about chronic pain and its treatment. This includes an evaluation of medical, psychiatric, and co-occurring substance use conditions, and the patient's social support system.
  - A comprehensive history and physical exam should be performed.
    - In addition to the biopsychosocial pain interview, the history includes asking and documenting all medications the patient is taking, including prescription, over the counter, homeopathic medications and medical marijuana.
    - The physical exam complements the history, and specifically includes a mental status exam, inspection, vital signs, posture and gait, palpation, range of motion, and neurologic exam, and relevant special physical exam maneuvers.
  - Certain laboratory examinations should be performed, as suggested by the history.
    - Obtain baseline urine drug testing.
    - NOTE: Assess pregnancy risk in all women of childbearing age including consideration for pregnancy testing.
- Review prior medical records and request consent to speak with prior prescriber.
- Check the AZ CSPMP record for the patient after verifying his or her identification.
- Explain to the patient that more information may be needed before determining an optimal treatment regimen, and explain the risks and benefits of individual or combinations of drugs.
- Introduce current best practices for treating chronic pain, including emphasis on self-management, non-pharmacologic, and non-opioid pharmacotherapy, setting functional treatment goals and prioritizing safe and sustainable treatment plans.
- **Based on the information gathered above, determine patient's level of risk.** Factors that constitute an increased risk for adverse outcomes include: having no prior medical records, declining to provide consent to speak with prior providers, history of non-concordant urine drug testing or PDMP histories, history of or active substance use disorder, comorbid psychiatric and medical conditions, co-prescription of opioids and benzodiazepines and prescribed opioid dose of MED≥90. A composite risk determination is made by integrating the above factors with the biopsychosocial assessment. Note that a medication regimen below MED of 90mg/day may still represent a high risk for adverse outcomes when other factors are present.
  - **For a lower risk patient/medication regimen:** Consider initially continuing inherited regimen while building rapport, setting longer term treatment goals which include evaluation for an opioid exit strategy, and optimizing non-pharmacologic and non-opioid pharmacotherapy.
    - It is important to address the person's pain from a whole person perspective. The goal of this first visit is not to get patients off their regimen, but to perform a biopsychosocial assessment, establish rapport, and set the stage for an evidence-based treatment plan.
    - Clarify both the short-term and long-term goals and expectations of the treatment plan.
      - Short-term goals may include establishing rapport with the patient and gathering more information on the person's health and lifestyle.
      - While supporting whole-person treatment, discuss the individualization of a careful exit strategy when indicated by a risk assessment: tapering, rotation to buprenorphine and gradual reduction of dose, or medication-assisted treatment. A rapid taper is not recommended.
    - Clarify office policies regarding controlled substance prescribing.
    - Use shorter prescribing and follow-up intervals to increase support and monitoring (e.g. two weeks).
  - **For a moderately high risk patient/medication regimen:** Consider initiating medication changes to improve safety while applying principles from these guidelines. The long-term treatment plan may include an exit strategy from the use of long-term opioid therapy for chronic pain (See *Appendix E*: *How to approach an exit strategy from long-term opioid therapy)*. It may not be appropriate to initiate opioid prescribing for patients who do not agree with a planned exit from long-term opioid therapy.
    - It is important to address the person's pain from a whole person perspective. The goal of this first visit is not to get patients off their regimen, but to perform a biopsychosocial assessment, establish rapport, and set the stage for an evidence-based treatment plan.
    - Clarify both the short-term and long-term goals and expectations of the treatment plan.
      - Short-term goals may include establishing rapport with the patient and gathering more information on the person's health and lifestyle.
      - While supporting whole-person treatment, discuss the individualization of a careful exit strategy when indicated by a risk assessment: tapering, rotation to buprenorphine and gradual reduction of dose, or medication-assisted treatment. A rapid taper is not recommended.
    - Clarify office policies regarding controlled substance prescribing.
    - Use shorter prescribing and follow-up intervals to increase support and monitoring (e.g. a few days to two weeks).
    - Include mental health support early when indicated and available.
    - **Assess for opioid use disorder** (See *Appendix C).*
      - If opioid use disorder is present, offer or arrange for MAT (See *Appendix D).*
      - If opioid use disorder is not identified, assess for the risk of continuing the most recent opioid regimen versus the risk of initiating a taper.
    - **Determine the risks of changing the regimen versus continuing the regimen.**
      - **If the risk of continuing the current regimen is determined to outweigh the risk of tapering:** initiate a gradual taper with close follow-up while optimizing non-opioid pharmacotherapy and non-pharmacologic treatments for chronic pain (See *Appendix E* for slower and slowest tapers). The initial opioid prescription may be at a reduced dose and generally for a shorter interval (a few days to a couple of weeks)
      - **If the risk of tapering is determined to outweigh the risk of continuing the patient's most recent opioid regimen** (verified by the CSPMP): consider continuing the patient's most recent regimen with shorter prescribing intervals and close follow-up or transitioning to buprenorphine and then tapering the buprenorphine. The risk assessment and assessment for opioid use disorder should be repeated regularly.

- **For a high-risk patient/medication regimen:** A situation like this means that the risk of continuing the current regimen is higher than the risk of changing the regimen. Avoid continuing the current treatment regimen, initiate safety planning (follow clinic policies and procedures to ensure safety if there is concern that the patient is a danger to self or others) and provide other treatment options (refer to mental health, substance use disorder treatment, interdisciplinary pain teams and withdrawal support if indicated).
  - **Assess for opioid use disorder** as these patients have a higher likelihood of having opioid use disorder (See *Appendix C* for Evaluation for Opioid Use Disorder).
    - **If there is a concern for opioid use disorder or if it is identified,** a warm handoff to a MAT provider is highly recommended if possible.
    - **If there is no concern for opioid use disorder, and it is determined that the risk of tapering is lower than the risk of not prescribing any opioid medications,** consider offering to provide a taper with close follow-up and prescribed small quantities (a few days to a week supply).
  - Assess for mental health, medical, and substance use disorder comorbidities and arrange for treatment as appropriate.
    - Often patients at high risk have underlying untreated psychiatric and/or substance use disorders. It is critically important to offer appropriate treatment options for these patients: mental health treatment for psychiatric conditions and opioid agonist therapy when opioid use disorder is suspected or identified (See *Guideline #15*).

NOTE: For all patients, consider utilizing case management resources offered by many managed care insurers. They can assist with integration of behavioral, social and medical issues that many providers lack resources to manage.

NOTE: If a provider is not comfortable taking over the prescriptions for low, medium or high-risk patients/regimens, one should work to get patients connected with appropriate treatment settings.

AFTER THE VISIT

- Do an initial follow-up and continue monitoring at a greater frequency (with shorter prescribing intervals), often every 1-2 weeks for the first several visits followed by every 2-4 weeks for the first 3-6 months.
  - Maintain focus on the balance of risks and benefits and adjust treatment plan as needed.
  - Maintain vigilance for emergence of opioid use disorder and symptoms of mental health conditions.
  - Incorporate new clinical information into the treatment plan.
    - For example, if the decision is initially made to take over prescribing while implementing a gradual opioid taper, and the patient subsequently displays unexpected high-risk behaviors (overusing opioids, obtaining opioids from other sources, reporting poor analgesic or functional response), re-evaluate with a whole person assessment. It may be appropriate to switch to a different strategy such as offering or arranging for MAT. If the risk of continuing the opioid taper is greater than the risk of stopping opioids, it may be appropriate to instruct the patient to taper with their existing supply of opioids while providing withdrawal support, non-opioid treatment options for pain, and appropriate whole person treatment options.

Consult with the OARLine (888-688-4222), an addiction clinician able to prescribe MAT, or a pain medicine physician for further guidance.

HOW TO'S GUIDANCE

HOW TO APPROACH AN EXIT STRATEGY (INCLUDING TAPERING)

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

Appendix E: How to Approach an Opioid Exit Strategy; *2018 Arizona Opioid Prescribing Guidelines*
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf

DESCRIPTION:

This Appendix comes from a forward thinking, evidence-based set of opioid prescribing guidelines.

Appendix E of these guidelines is "How to Approach an Opioid Exit Strategy", of which there are three: 1) tapering 2) rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose, and 3) medication for addiction (MAT) for opioid use disorder. It also includes the treatment options for withdrawal symptoms.

HOW TO USE:

Other than using pharmacotherapy for opioid use disorder when present, there is little evidence to guide which opioid exit is best for an individual. This Appendix lists considerations for an exit strategy for different patient presentations. Of note, a switch to another exit strategy may be indicated as the clinical course continues.

Another resource for opioid tapering includes the VA Academic Detailing in-depth Opioid Taper Decision Tool and the 2-page patient education tool. The 2-page tool is included in print version in the front of this booklet and both can be located online

(https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/52_Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf) and here.

APPENDIX E: HOW TO APPROACH AN EXIT STRATEGY FROM LONG-TERM OPIOID THERAPY

The goal of treatment of patients on long-term opioid therapy is not to reduce opioid prescriptions to zero. The goal is to maintain or improve safety while working to maximize function.

Opioid tapering is the seemingly logical approach to stopping long-term opioid therapy and patients can experience improved pain, function and quality of life when opioids are tapered and discontinued, particularly when tapering occurs in the context of a whole-person care plan. There are some patients, however, such as those with opioid use disorder, for whom tapering may contribute to the overall risk calculation (e.g. possibly increasing the risk of illicit opioid acquisition or worsening of underlying psychiatric illnesses).

Clinicians should consider a broader concept of an opioid exit strategy. As recommended in *Guideline #17*, two additional exit strategies beyond tapering (Strategy (a)) include rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose (Strategy (b)), and medication-assisted treatment for patients with opioid use disorder (Strategy (c)). There is clear evidence for the effectiveness of treating an opioid use disorder with medication-assisted treatment, but otherwise little evidence to guide which opioid exit strategy is best for an individual. The following can be considered in choosing an initial strategy, but a switch to another strategy can be made at any time, depending on the clinical situation:

- For patients with prescriptions of lower MEDs, lower pain-related dysfunction, and lower psychiatric and substance use disorder comorbidities, consider opioid tapering (Strategy (a)). See the Opioid Tapering subsection within this *Appendix.*
- For patients with prescriptions of higher MEDs, higher pain-related dysfunction and higher psychiatric and substance use disorder comorbidities, consider Strategy (b), rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose.
- For patients with opioid use disorder, offer or arrange for medication assisted treatment (Strategy (c)). See *Guideline #15* and *Appendices C* and *D* for diagnosis and management of opioid use disorder.

Complex persistent opioid dependence is a condition recently described in the literature as a clinical and physiologic state that exists on the continuum between simple opioid dependence (which presents with short-lived and self-limited withdrawal symptoms after opioids are discontinued) and opioid use disorder (defined by DSM-5 criteria). In these patients, opioid tapering or cessation may lead to worsening pain, function, affective symptoms and sleep disturbances. As of the writing of this guideline, there is no clear evidence to guide the best exit strategy for these patients, but options include Strategy (a) (opioid tapering), while optimizing treatment of psychiatric comorbidities, non-pharmacologic and non-opioid pharmacotherapy for pain or (Strategy (b)), buprenorphine followed by its gradual dose reduction.

Abrupt opioid discontinuation is not recommended unless required for immediate safety concerns.

Opioid Tapering

Opioid tapering is rarely urgent or emergent. Too aggressive of tapering or tapering without patient engagement may lead to patients seeking illicit opioids, which can result in overdose and death. The risks of aggressive tapering can outweigh the risks of continuing long-term opioid therapy.

For patients who are not engaged and open to tapering, re-evaluate for the presence of under-treated mental health conditions, substance use disorders, and other psychosocial stressors. If present, develop a whole person treatment plan to address these factors. A collaborative process is likely to maximize positive patient expectations and minimize negative expectations which can have a major effect on the patient's chronic pain and likelihood of overall improvement with an opioid taper plan.

The following risks should be taken into consideration when determining the overall risks with long-term opioid therapy for pain, recognizing that having multiple risk factors indicates a larger, cumulative risk:

- No pain reduction, no improvement on opioid regimen
- Severe, unmanageable adverse effects (drowsiness, constipation)
- High risk dosage (e.g. ≥90 MED)
- Non adherence to treatment plans
- Concerns related to an increased risk of substance use disorder
- Overdose event involving opioids
- Medical comorbidities that can increase risk (e.g. lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age)
- Concomitant use of medications that increase risk (benzodiazepines, sedative-hypnotics)
- Mental health comorbidities that can worsen with opioid therapy (e.g. PTSD, depression, anxiety)

Before Starting Taper

- Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper, such as mental health disorders, opioid use disorder and other substance use disorders, medical comorbidities and sleep disorders.
- Discuss risks and benefits of continued use of opioids with patient, including that tolerance to the prior opioid dose can be lost within a week and people are at risk of an overdose if they resume their prior dose.[97]
- Offer Naloxone as a safety measure to all patients at risk for overdose (See *Guideline #16*).
- Identify a multimodal care team, made up of behavioral health specialists and addiction specialists to assist during the taper.
- Acknowledge fears about tapering, and help patients develop goals for life (besides being "pain-free") and offer other nonpharmacological or non-opioid medications.
- Determine speed of taper: Slow tapers are often the most tolerable and can be completed over several months to years, but more rapid tapers may be required in instances like illegal or dangerous behaviors or situations where the risks of continuing the opioid outweigh the risks of a rapid taper.

Example Tapers for Opioids[98 99 100 101 102]

Slowest Taper (over years)	Slower Taper (over months to years) *MOST COMMON*	Faster Taper (over weeks)	Rapid Taper (over days)
Reduce MEDs by 2-10% every 4-8 weeks with pauses in taper as needed.	Reduce MEDs by 5-20% every 4 weeks with pauses in taper as needed.	Reduce MEDs by 10-20% every week.	Reduce MEDs by 20-50% of first dose if needed, then reduce by 10-20% every day.

Follow-up and Support During Taper

- Provide opioid overdose education and prescribe naloxone to patients, given the reduced tolerance to opioids and availability of opioids in the community (See *Guideline #16*).
- Follow-up on patient function, pain intensity, sleep, physical activity, personal goals and stress level – the frequency and location of follow-up determined by the tapering approach.

Follow-up during opioid tapers[98 99 100 101 102]			
Slowest Taper (over years)	**Slower Taper (over months to years) *MOST COMMON***	**Faster Taper (over weeks)**	**Rapid Taper (over days)**
Follow up every 1-4 weeks after starting taper then monthly before each reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up every 1-4 weeks after starting taper then monthly before each reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up weekly before each dose reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up daily before each dose reduction or offer inpatient admission.

- For patients who struggle with opioid tapering, consider slowing or pausing the taper and evaluate for psychiatry comorbidities and substance use disorders. A switch to another exit strategy may be appropriate. Consider switching to Strategy (b), rotation to buprenorphine with subsequent gradual tapering over several months if complex persistent opioid dependence is suspected. Further, consider switching to Strategy (c), (medication assisted treatment) if opioid use disorder is recognized during the tapering process of the opioid or buprenorphine dose.
- Generally, withdrawal symptoms can be minimized or avoided with gradual tapers. Reassure patients that withdrawal symptoms can be managed with medication and non-medication treatments (e.g. meditation, relaxation, deep breathing).[42 98 99 100 101 102 103 104 105 106 107 108 109] Withdrawal symptoms should not be treated with an opioid or benzodiazepine. Treatment should be provided or arranged when these conditions are present.

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	First line: Clonidine; Alternatives: Baclofen, Gabapentin, Tizanidine
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine, Diphenhydramine
Myalgias	NSAIDs, Acetaminophen, Topical medications like menthol/methyl salicylate cream, lidocaine cream/ointment
Sleep disturbance	Trazodone
Nausea	Prochloperazine, Promethazine, Ondansetron
Abdominal cramping	Dicyclomine
Diarrhea	Loperamide, Bismuth subsalicylate

CLINICAL TOOLS FOR OPIOID USE DISORDER

HOW TO DIAGNOSE OPIOID USE DISORDER

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

Appendix C: "How to Evaluate Patients for Opioid Use Disorder," *2018 Arizona Opioid Prescribing Guidelines*
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribingguidelines/az-opioid-prescribing-guidelines.pdf

DESCRIPTION:

This appendix comes from a forward thinking, evidence-based set of opioid prescribing guidelines.

Appendix C of these guidelines is "How to Evaluate Patients for Opioid Use Disorder." It includes the reasons to screen, how to evaluate (since there is no validated screening tool), and the definition and diagnostic criteria for opioid use disorder from the *DSM-5*.

HOW TO USE:

The lifetime prevalence for opioid use disorder among patients receiving long-term opioid therapy has been estimated to be between 25-41%. It is an Arizona Guideline recommendation and best practice to assess patients for opioid use disorder on a regular basis, and to offer or arrange for pharmacotherapy if present.

APPENDIX C: HOW TO EVALUATE PATIENTS FOR OPIOID USE DISORDER[88]

The lifetime prevalence for opioid use disorder among patients receiving long-term opioid therapy has been estimated to be between 25-41%.[42]

Guideline #15 states to assess patients for opioid use disorder on a regular basis, and to offer or arrange for opioid agonist therapy to those diagnosed. There are screening tools available that can predict the likelihood of aberrant behaviors (e.g. Opioid Risk Tool, SOAPP-R), but they are not designed to screen for opioid use disorder and their sensitivity is low. **Providers should seek to identify clinical evidence of opioid use disorder, rather than relying on screening tests with low sensitivity.** When assessing for opioid use disorder and discussing opioid agonist therapy, clinicians should also aim to destigmatize the condition and the treatment. Reviewing the brain model of addiction[89] and comparing to other conditions (e.g. diabetes) that also require ongoing self-management and medication use can be helpful.

Definition and Diagnostic Criteria

Opioid use disorder (OUD) is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested **by at least two of the symptoms** below, occurring within a 12-month period. This can also be remembered through the "3Cs": Loss of **Control**, **Craving**, and Use despite Negative **Consequences**.

DSM-5 Diagnostic Criteria for Opioid Use Disorder[90]

LOSS OF CONTROL	Using larger amounts of opioids or over a longer period than initially intended	EXAMPLE: taking more than prescribed (e.g. repeated requests for early refills)
	Persistent desire or inability to cut down on or control opioid use	EXAMPLE: has tried to reduce dose or quit opioid because of family's concerns about use but has been unable to
	Spending a lot of time to obtain, use or recover from opioids	EXAMPLE: driving to different doctors' offices to get renewals for various opioid prescriptions
CRAVING	Craving or strong desire or urge to use opioids	EXAMPLE: describing constantly thinking about/needing opioid
USE DESPITE NEGATIVE CONSEQUENCES	Failure to fulfill obligations at work, school or home due to use	EXAMPLE: not finishing tasks due to effect of taking opioids; getting fired from jobs
	Continued opioid use despite persistent or recurrent social or interpersonal problems related to opioids	EXAMPLE: spouse of family member worried or critical about patient's opioid use
	Activities are given up or reduced because of use	EXAMPLE: no longer participating in weekly softball league despite no additional injury or reason for additional pain
	Recurrent use in situations that are physically hazardous	EXAMPLE: repeatedly driving under the influence
	Continued use despite physical or psychological problems related to opioids	EXAMPLE: unwilling to discontinue or reduce opioid use despite non-fatal accidental overdose
PHYSIOLOGIC CRITERIA	Tolerance*	EXAMPLE: needing to take more to achieve the same effect
	Withdrawal*	EXAMPLE: feeling sick if opioid not taken on time or exhibiting withdrawal effects

*Tolerance and withdrawal are not counted as DSM V criteria for opioid use disorder when the patient is taking opioid medications as prescribed.

The severity of opioid use disorder is classified by the number of presenting symptoms.

DSM-5 Diagnostic Criteria for Severity of Opioid Use Disorder[90]	
Mild Severity of Opioid Use Disorder	Presence of 2-3 symptoms above
Moderate Severity of Opioid Use Disorder	Presence of 4-5 symptoms above
Severe Severity of Opioid Use Disorder	Presence of 6 or more symptoms above

If there is uncertainty whether a patient meets criteria for opioid use disorder, refer the patient to an addiction specialist or psychiatrist for diagnosis.

Next Steps

People with opioid use disorder are at risk for using illicit opioids (e.g. heroin or counterfeit pills, both of which can contain potent synthetic fentanyl) which can lead to death with small exposures.

- Avoid abrupt discontinuation or rapid tapering of opioid therapy unless there are certain high-risk circumstances (e.g. evidence for diversion, threatening behavior, serious disruptive behavior, suicidal ideation or behaviors).
- Offer patients with opioid use disorder opioid agonist therapy (e.g. methadone and buprenorphine) along with integrated pain and mental health therapy. This treatment can prevent overdose and death. Tapering alone is not sufficient treatment for this group.
- Recognize that opioid use disorder typically requires chronic management, although full remission can be achieved.

A Note on Diversion

Drug diversion is a crime and constitutes an absolute contraindication to prescribing additional medications. Drug diversion can be suspected if the patient history and clinical picture do not align, such as the absence of prescribed medications in a confirmatory urine drug test and no signs of clinical withdrawal despite a patient reported history of taking prescribed medications.

- Providers who suspect diversion should base treatment plans on objective evidence. Evidence can include a negative confirmatory urine drug test (e.g. gas chromatography/mass spectrometry or liquid chromatography/ mass spectrometry) for the substance being prescribed in the absence of withdrawal symptoms in someone who is receiving opioids. There is a limitation in this, however, as most routine urine drug screens do not detect synthetic opioids (e.g. methadone, fentanyl, tramadol) and may not detect semi-synthetic opioids (e.g. oxycodone, hydrocodone, hydromorphone).
- If there is evidence that the patient is diverting opioids, discontinue opioids and assess for underlying opioid use disorder and/or psychiatric comorbidities. Consultation with a pain specialist, psychiatrist, or substance use disorder specialist may be warranted. Consider additional consultation with risk management and/or legal counsel. For patients with opioid use disorder, opioid agonist therapy should be offered or arranged (See *Guideline #13*).

HOW TO'S GUIDANCE

OPIOID WITHDRAWAL ATENNUATION COCKTAIL

OPG
OREGON PAIN GUIDANCE

RESOURCE

Opioid Withdrawal Attenuation Cocktail
https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-Withdrawal-Attenuation-Cocktail.pdf?x91687

DESCRIPTION:

This "cocktail" from Oregon Pain Guidance has specific dosing recommendations and is meant to help manage acute opioid withdrawal as well as an anticipated withdrawal as part of a planned taper (more likely in an outpatient primary care setting). It is consistent with what is listed in the *2018 Arizona Opioid Prescribing Guidelines*, Appendix E.

HOW TO USE:

Clinicians should consider the patient's preferences and safety factors when creating a taper plan with them. Gradual tapers should generally avoid the patient having significant opioid withdrawal symptoms. In certain situations, safety factors or patient preference may lead to creating a faster taper and both pharmacologic and non-pharmacologic tools can be used to mitigate withdrawal symptoms.

Anxiety, irritability, insomnia, and increased pain can occur with even very gradual tapers and medications such as gabapentinoids, baclofen, or tizanidine may be helpful. Non-pharmacologic approaches include self-care strategies such as exercise, mindfulness, meditation, engagement in pleasant activities, and social engagement. Non-pharmacologic approaches delivered by the healthcare team include close follow-up and supportive counseling by the healthcare team, psychological therapies (e.g. cognitive behavioral therapy, acceptance and commitment therapy, and mindfulness-based stress reduction), physical therapy, and acupuncture.

OPIOID WITHDRAWAL ATTENUATION COCKTAIL

Acute Withdrawal

Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID. May have opioid effects at high doses.
Alternatively, consider Hycosamine 0.125mg q 4-6 hrs PRN

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs

Anxiety: Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check QTc)

Anticipated Withdrawal as a Part of a Planned Taper

Anxiety: Gabapentin Escalating Dose to 1200mg/day. Start loading one month prior to planned taper.

Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs

Anxiety: Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check EKG for QTc interval)

This information and other tools are available online at www.oregonpainguidance.org/clinical-tools.

HOW TO'S GUIDANCE

HOW TO TAPER BENZODIAZEPINES

OPG
OREGON PAIN GUIDANCE

RESOURCE

Benzodiazepine Tapering Flow Sheet
https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf?x91687

(Other option) VA's Academic Detailing Service (Discussion Guide)
https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/24_Benzodiazepines_Provider_AD_Risk_Discussion_Guide_IB10_953.pdf

(Other option) VA's Academic Detailing Service (Educational Guide)
https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/22_Benzodiazepine_Provider_AD_Educational_Guide_IB_10_928.pdf

DESCRIPTION:

The OPG guidance can assist in reducing the risk of long-term use of benzodiazepines. There is a benzodiazepine equivalency chart and instructions for slow and rapid tapers. Of note, while use of benzodiazepines in the short-term may be effective and indicated in some clinical settings, long-term use has little proven benefit and poses serious risks.

HOW TO USE:

Even though benzodiazepines are recommended only for short-term use and for narrow indications, long-term use of benzodiazepines for anxiety, sleep, depression, and PTSD is widespread. There can be serious adverse consequences associated with benzodiazepines, including depressed mood, disinhibition, cognitive impairment, falls/hip fractures, traffic accidents, tolerance/dependence, accidental overdose (particularly when combined with other sedatives like alcohol, opioids, etc.).

Certain populations have a higher risk of adverse events than the general population:

- Co-administration with opioids
- PTSD
- Elderly
- Dementia
- Chronic respiratory disease

Clinicians should consider tapering benzodiazepines when the potential harms outweigh the potential benefits.

Unlike from opioids, withdrawal from benzodiazepines can be medically serious and become life-threatening. For this reason, abrupt discontinuation after long-term use is generally not indicated and a gradual taper is the best approach when clinically appropriate.

If the patient is experiencing significant withdrawal symptoms during a taper, clinicians should consider pausing or slowing the taper pace. Switching to a longer acting agent such as diazepam may be helpful, and because diazepam is available in 2mg tablets, small dosage forms (e.g. 1mg increments) are easily available to facilitate a gradual taper. (Note: diazepam can accumulate in patients with hepatic impairment and cause prolonged sedation.)

Highly motivated patients may prefer a quicker taper (e.g. 4-12 weeks).

Benzodiazepine Tapering Flow Sheet

START HERE

Consider benzodiazepine taper for patients with aberrant behaviors, behavioral risk factors, impairment, or concurrent opioid use.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

BENZODIAZEPINE TAPER

Basic principle: Expect anxiety, insomnia, and resistance. Patient education and support will be critical. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

SLOW TAPER

1. Calculate total daily dose. Switch from short-acting agent (alprazolam, lorazepam) to longer-acting agent (diazepam, clonazepam, chlordiazepoxide, or phenobarbital). Upon initiation of taper, reduce the calculated dose by 25–50% to adjust for possible metabolic variance.
2. Schedule first follow-up visit two to four days after initiating taper to determine if adjustment in initial calculated dose is needed.
3. Reduce the total daily dose by 5–10% per week in divided doses.
4. After ¼ to ½ of the dose is reached, you can slow the taper with cooperative patient.
5. With cooperative patients who are having difficulty with this taper regimen, you can extend the total time of reduction to as much as six months.
6. Consider adjunctive agents to help with symptoms: trazodone, hydroxyzine, neuroleptics, anti-depressants, clonidine, and alpha-blocking agents.

RAPID TAPER

1. Pre-medicate two weeks prior to taper with valproate 500mg BID or carbamazepine 200mg every AM and 400mg every HS. Continue this medication for four weeks post-benzodiazepines. Follow the usual safeguards (lab testing and blood levels) when prescribing these medications.
2. Utilize concomitant behavioral supports.
3. Discontinue current benzodiazepine treatment and switch to diazepam 2mg BID for two days, followed by 2mg every day for two days, then stop. For high doses, begin with 5mg BID for two days and then continue as described.
4. Use adjuvant medications as mentioned above for rebound anxiety and other symptoms.

Benzodiazepine Equivalency Chart

Drug	Half-life (hrs)	Dose Equivalent
Chlordiazepoxide (Librium)	5–30 h	25mg
Diazepam (Valium)	20–50 h	10mg
Alprazolam (Xanax)	6–20 h	0.5mg
Clonazepam (Klonopin)	18–39 h	0.5mg
Lorazepam (Ativan)	10–20 h	1mg
Oxazepam (Serax)	3–21 h	15mg
Triazolam (Halcion)	1.6–5.5 h	0.5mg
Phenobarbital (barbituate)	53 – 118 h	30 mg

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NALOXONE

ARIZONA DEPARTMENT
OF HEALTH SERVICES

NALOXONE

NALOXONE STANDING ORDER

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

Arizona Naloxone Standing Order
Search for “standing orders” at www.azhealth.gov

DESCRIPTION:

There is an active standing order for naloxone posted at the Arizona Department of Health Services website. This order authorizes any Arizona-licensed pharmacist to dispense naloxone to any individual in accordance with the conditions of this order, without the person requiring a prescription with their name and date of birth.

HOW TO USE:

Patients can be given this standing order or simply advised to go to a pharmacy to access naloxone. Patients, friends, family members, community leaders, etc. will still need to pay for the medication through their insurance, but the barrier of having a personalized prescription has been removed with this standing order. Pharmacists who are unaware of the standing order can find it on the Arizona Board of Pharmacy website.

ARIZONA DEPARTMENT OF HEALTH SERVICES

STANDING ORDERS FOR NALOXONE

This standing order is issued by Dr. Cara Christ, MD MS (NPI #1639369036), Director of Arizona Department of Health Services. The standing order authorizes any Arizona-licensed pharmacist to dispense naloxone to any individual in accordance with the conditions of this order.

Dispense one of the three following naloxone products based on product availability and preference.

☐	**For intranasal administration in children ≥5 years or ≥20kg; adolescents; adults** Dispense: NARCAN™ 4mg/0.1mL nasal spray Sig: For suspected opioid overdose, administer a single spray of Narcan in one nostril. Repeat after 3 minutes if no or minimal response. Refills: PRN x 1 year **OR** Dispense: 2mg/2mL single dose Luer-Jet prefilled syringe. Include 1 Luer-lock mucosal atomization device per dose dispensed. Sig: For suspected opioid overdose, spray 1 mL in each nostril. Repeat after 3 minutes if no or minimal response. Refills: PRN x 1 year
☐	**For intramuscular injection in children ≥5 years or ≥20kg; adolescents; adults** Disp: 0.4mg/mL in 1mL single dose vials. Include one 3cc, 23g, 1" syringe per dose dispensed. Sig: For suspected opioid overdose , inject 1mL IM in shoulder or thigh, PRN opioid overdose. Repeat after 3 minutes if no or minimal response. Refills: PRN x 1 year
☐	**For intramuscular or subcutaneous injection in children ≥5 years or ≥20kg; adolescents; adults** Disp: EVZIO™ 2mg/0.4mL auto-injector, #1 Two-pack Sig: For suspected opioid overdose, follow audio instructions from device. Place on thigh and inject 0.4mL. Repeat after 3 minutes if no or minimal response. Refills: PRN x one year

CM Christ MD

Cara Christ, MD MS, Director of Arizona Department of Health Services

Effective date 11/07/18, Expiration date 11/07/20

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

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Health and Wellness for all Arizonans

NALOXONE

NALOXONE TRAINING AND EDUCATION

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

Naloxone Administration Brochure
https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioidprevention/naloxone-brochure-public.pdf

DESCRIPTION:

This handout includes the visual instructions on how to administer all three forms of naloxone: injection, nasal spray, and autoinjector.

HOW TO USE:

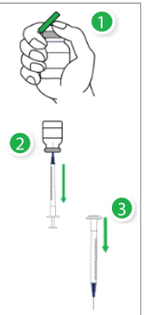
This brochure can be accessed online, or ordered in print form from azopioid@azdhs.gov.

In case of overdose:

1. **CALL 911 - Give naloxone** — If no reaction in 3 minutes, give second naloxone dose if available
2. **Rescue breathing or chest compressions** — Follow 911 dispatcher instructions
3. **After naloxone** — Stay with person for at least 3 hours or until help arrives

Injection

VIAL



1—Flip off the cap to reveal latex seal.

2—Turn vial upside down. Pull plunger to draw up liquid.

3—Inject into muscle. Press plunger all the way down to trigger safety. (retraction)

AMPULE

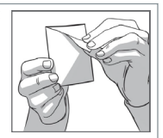
1—Tap ampule to send all liquid to the bottom.

Push top away from you to snap open the ampoule.

2—Pull plunger to draw up liquid.

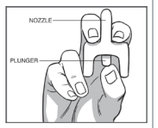
3—Inject into muscle. Press plunger all the way down to trigger safety. (retraction)

Nasal spray



1—Remove naloxone nasal spray from the box.

2—Peel back the tab with the circle to open the naloxone nasal spray.



3—Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

4—DO NOT PRIME OR TEST THE SPRAY DEVICE. Tilt the person's head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into one nostril, until your fingers on either side of the nozzle are against the bottom of the person's nose.

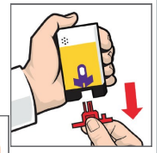
5—Press the plunger firmly to give the dose. Remove the spray device from the nostril.

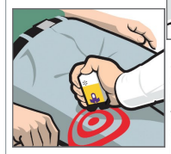
6—If no reaction in 2-3 minutes or if person stops breathing again, give the second dose of naloxone in the OTHER nostril using a NEW spray device.

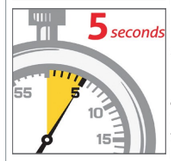
Auto-injector

1—Pull the auto-injector from the outer case.

2—Pull firmly to remove the red safety guard (do not touch the black base).







3—Place the black end against the middle of the outer thigh, through clothing if necessary, then press firmly and hold in place for 5 seconds.

4—If no reaction in 2-3 minutes or if the person stops breathing again, give the second dose of naloxone using NEW auto-injector.

DATA-WAIVER TRAINING

ARIZONA DEPARTMENT
OF HEALTH SERVICES

DATA-WAIVER TRAINING

DATA-WAIVER TRAINING

RESOURCE

DATA-Waiver Training for Clinicians through the Providers Clinical Support System (PCSS)
https://pcssnow.org/medication-assisted-treatment/

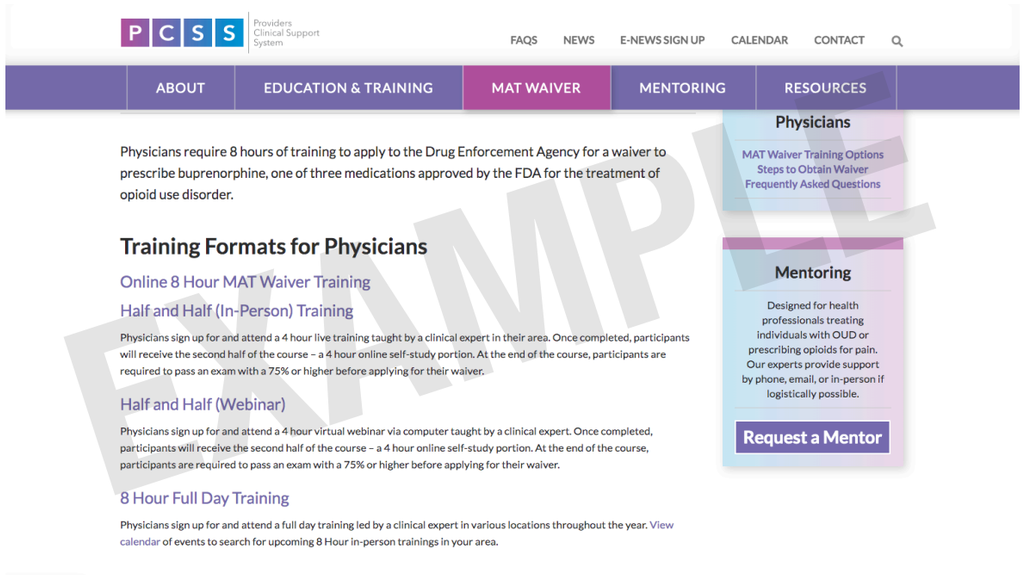
DESCRIPTION:

The Providers Clinical Support System (PCSS) is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that maintains an electronic repository of training materials and educational resources to support evidence-based treatment of opioid use disorder and chronic pain. Of note, PCSS provides DATA-waiver training in several formats (online, half online/half in-person, in-person) for physicians, nurse practitioners and physician assistants for no cost.

HOW TO USE:

Clinicians can access this training and take the required training for the DATA-waiver, for free (8 hours for physicians and 24 hours for NPs and PAs).

Instructions on the website also describe how to obtain the final "X" for the DATA-waiver by submitting the PCSS certification of completion. The submittal process can be initiated at http://buprenorphine.samhsa.gov/forms/select-practitioner-type.php.



ARIZONA LAWS + RESOURCES

ARIZONA DEPARTMENT
OF HEALTH SERVICES

RESOURCE

Summary of Arizona Laws Impacting Opioid Prescription
SB 1001: Opioid Epidemic Act
HB 2548: health professionals; continuing education; opioids
HB 2549: controlled substances; dosage limit
HB 2633: pharmacists; controlled substances
SB 1111: workers' compensation; opioids; dispensed medications

DESCRIPTION:

This is a high-level summary of the Opioid Epidemic Act in Arizona and supplementary legislation. The legislation is complex, and the following overview should not suffice for implementation. Hyperlinks to the relevant bills are included above, and providers should read the text of the legislative language and consult with lawyers if necessary.

1. Initial fill limits [SB 1001]
    a. There is a limit on "initial prescriptions" to all patients for a Schedule II opioid controlled substance to no more than a 5-day supply (with exceptions).
    b. There is a limit on "initial prescriptions" to all patients following a surgical procedure for a Schedule II opioid controlled substance to no more than a 14-day supply (with exceptions).
    c. The definition of "initial prescription" is a Schedule II opioid controlled substance that has not been dispensed to the patient at any time during the previous 60 days, as confirmed by the CSPMP.
    d. EXCEPTIONS: There are numerous exceptions listed in the bill, including prescriptions for hospice, palliative care and burns.
    e. ENFORCEMENT: Health professional regulatory boards will enforce provisions through a complaint process; pharmacists are not required to verify if initial prescriptions are compliant with the initial fill limits.
2. Dosage limits [SB 1001, HB2549, HB 2633]
    a. There is a limit on issuing a new prescription order (meaning not within the previous 60 days) that exceeds 90 MME per day and is filled or dispensed outside of a healthcare institution (with exceptions).
    b. A healthcare professional may only issue a new prescription above 90 MME/day to a nonexempt patient if they are board-certified in pain or have consulted with a physician who is board-certified in pain. Consultation services are available through the OAR Line at 888-688-4222. Each of the health professional regulatory boards must determine qualifications for "board-certified in pain" for the purposes of enforcement.
    c. If a patient is prescribed a new or continuing prescription for more than 90 MME/day, the prescriber must also prescribe Naloxone hydrochloride or any other opioid antagonist approved by the FDA for the treatment of opioid-related overdoses.

d. EXCEPTIONS: There are exceptions listed in the bill, including for atypical opioids like buprenorphine, tramadol and tapentadol.

e. ENFORCEMENT: Health professional regulatory boards will enforce through a complaint process; pharmacists are not required to verify if prescriptions are compliant with the dosage limits.

3. Electronic prescribing [SB 1001, HB 2633]

a. Beginning January 1, 2020 each prescription order for a Schedule II opioid must be transmitted through an electronic prescription for controlled substances (EPCS) to the dispensing pharmacy.

b. EXCEPTIONS: Electronic prescribing does not apply to MAT prescription orders, if the eprescribing system is inoperable, for patients in IHS and federal facilities, for direct administration to a patient, and patients in long-term care or hospice facilities. Additional exceptions may be determined by the Arizona Board of Pharmacy.

c. ENFORCEMENT: Health professional regulatory boards will enforce provisions through a complaint process; pharmacists are not required to verify if a prescriber has been granted a waiver from e-prescribing requirements.

4. Continuing Medical Education [SB 1001, HB2548]

a. There is a requirement for any healthcare professional authorized to prescribe Schedule II controlled substances or who is authorized to dispense (pharmacists) controlled substances to complete a minimum of three hours of opioid-related, substance use disorder-related, or addiction-related continuing medical education (CME) each license renewal cycle as part of their existing requirements.

b. ENFORCEMENT: Health professional regulatory boards will enforce provisions through their own determined process.

5. CSPMP [SB 1283, SB 1001]

a. Prescribers are mandated to check the Arizona Controlled Substances Prescription Monitoring Program (CSPMP) for the preceding 12 months before prescribing an opioid analgesic of benzodiazepines for a new patient treatment or quarterly for patients receiving continuing treatment. Pharmacists are also required to check the CSPMP for the preceding 12 months before dispensing for a new course of treatment.

b. Specifically Schedule II, III or IV medications need to be checked for the previous twelve months.

c. EXCEPTIONS: There are numerous exceptions for the provider mandate, including if the patient is receiving hospice or palliative care, receiving care for cancer, receiving the controlled substance during inpatient or residential treatment, or if there is a technological failure, etc. If there is uncertainty about qualification for exemption, it is recommended to check the CSPMP.

d. ENFORCEMENT: Health professional regulatory boards will enforce provisions through their own determined process.

e. Of note, unauthorized use of PMP data is a class 6 felony.

6. Regulation of Pain Management Clinics [9 A.A.C. 10, Article 20]

a. Pain management clinics must now meet the same licensure requirements as other ADHS-licensed healthcare facilities.

b. “Pain management clinic” is defined as a healthcare institution or private office or clinic in which a majority of patients in any month are prescribed opioids, benzodiazepines, barbiturates or carisoprodol for more than 90-days in a 12-month period. This does not include MAT prescriptions.

c. Pain management clinics must have a licensed physician or nurse practitioner with advanced pain certification to serve as the medical director.

d. In addition to regular licensure requirements, pain management clinics are subject to administrative rules for informed consent, reporting, physical examination requirements, etc.

e. ENFORCEMENT: The Arizona Department of Health Services Division of Licensing will enforce provisions through their normal process.

7. Dispensing restrictions [SB 1001, HB 2549]

a. There is now a prohibition against all healthcare professionals from dispensing (with exceptions) Schedule II controlled substances that are opioids (act of unprofessional conduct).

b. EXCEPTIONS: Exceptions for prescriptions include those for MAT and implantable devices.

c. ENFORCEMENT: Health professional regulatory boards will enforce provisions through their own determined process.

8. Prior Authorization Reforms [SB 1001]

a. There are now maximum timeframes for health plans to finalize prior authorization requests and resolve appeals: 5 days for urgent services and 14 days for non-urgent services, with some exceptions.

b. Prior authorizations for chronic pain conditions, unless conditions change, are valid for at least 6 months or until the last day of coverage.

c. Additional requirements for electronic submission of prior authorization requests, appeals, etc. were included.

d. ENFORCEMENT: The Arizona Department of Insurance is responsible for enforcement.

9. Medication Assisted Treatment [SB 1001]

a. There is now a requirement for structured sober living homes to develop policies and procedures to allow individuals on MAT to continue receiving the treatment while living in a structured sober living home.

b. There is now a requirement for health plans to allow at least one medically-assisted treatment be available without prior authorization.

10. Substance Abuse Initiatives [SB 1001]

a. There is now a requirement for counties to establish a drop-off location for legal or illegal substances and drug paraphernalia.

b. There is now a requirement for healthcare institutions to refer a patient who is discharged after receiving emergency services for a drug-related overdose to a behavioral health services provider.

11. Reporting Requirements [9 A.A.C. 4, Article 6]

a. All healthcare providers and administrators of healthcare institutions must report suspected opioid overdoses, suspected opioid deaths, and Naloxone doses *administered*. Use of MEDSIS is encouraged.

b. Pharmacists must report Naloxone doses *dispensed* to the PMP.

c. Reports must be submitted five business days after the incident.

d. ENFORCEMENT: Health professional regulatory boards will enforce provisions along their own determined process and the Arizona Department of Health Services Division of Licensing will enforce provisions for licensed healthcare institutions through their normal process.

HOW TO USE:

This information is further detailed in the AzRxEd.org free online CME modules.

ARIZONA PRESCRIPTION DRUG MONITORING PROGRAM

RESOURCE

Arizona State Board of Pharmacy, Arizona Prescription Drug Monitoring Program
https://pharmacypmp.az.gov/

DESCRIPTION:

The Arizona State Board of Pharmacy Controlled Substances Prescription Monitoring Program grants access to prescribers and pharmacists so they may review controlled substance dispensing information for patients. There is no fee to the prescriber for PMP registration.

§ A.R.S. 36-2606 requires each medical practitioner licensed under Title 32 (i.e. MD, DO, DDS, DMD, DPM, HMD, PA, ND and OD) and who possesses a DEA license to review the preceding 12 months of a patient's PMP record before prescribing an opioid analgesic or benzodiazepine controlled substance listed in Schedule II, III or I. Exceptions are described as well.

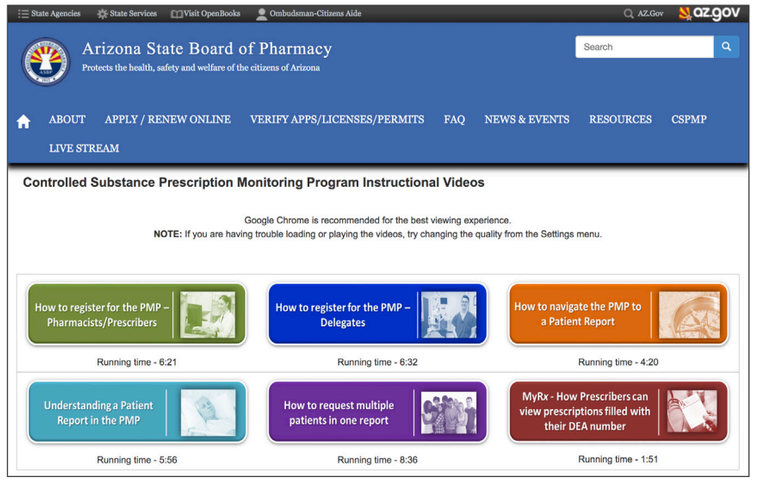
On the program website, there are also six instructional videos, each between 4-9 minutes long, that show how to register to the PMP, how to register delegates, how to navigate and understand a PMP report, and how prescribers can view prescriptions filled with their DEA number.

HOW TO USE:

For registration: https://pharmacypmp.az.gov/

For PDMP Technical Assistance: 855-929-4767

For general information: 602-771-2732



2018 ARIZONA OPIOID PRESCRIBING GUIDELINES

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

2018 Arizona Opioid Prescribing Guidelines
https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf

DESCRIPTION:

This is a forward thinking, evidence-based set of opioid prescribing guidelines. In addition to addressing the use of opioids, it also includes the evidence-based management of acute and chronic pain and the screening and diagnosis of opioid use disorder. The guidelines are up-to-date and highlight the best-evidence that drove each guideline and recommendation. There are numerous “HOW TO” Appendices to assist in the clinical setting.

This document has been endorsed by 19 Arizona health care associations and agencies.

HOW TO USE:

Online copies of the guidelines are posted at azdhs.gov (search for “prescribing guidelines”). Hard copies of the guidelines can be ordered and shipped free of charge by emailing azopioid@azdhs.gov. Highlights of these guidelines are also included in the AzRxEd.org free CME modules and are utilized by the Arizona OAR Line.

SUMMARY GUIDELINES FOR THE TREATMENT OF ACUTE AND CHRONIC PAIN

There are more than two Arizonans dying every day from an opioid overdose, and the majority of deaths are due to prescription opioids. It is imperative that Arizona clinicians have prescribing practices that maintain safety for their patients and community, while also addressing their patients' pain.

The following seventeen guidelines for non-cancer, non-terminal pain are designed to provide information and assist decision-making for providers. Each patient and clinical presentation is unique, however, and these statements must not supersede medical judgment and risk-benefit analyses.

ACUTE PAIN

1	Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.
2	If opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration; reassess if pain persists beyond the anticipated duration.
3	Do not use long-acting opioids for the treatment of acute pain.

CHRONIC PAIN

4	Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.
5	Do not initiate long-term opioid therapy for most patients with chronic pain.
6	Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders and behavioral health conditions.

RISK MITIGATION

7	For patients on long-term opioid therapy, document informed consent which includes the risks of opioid use, options for alternative therapies and therapeutic boundaries.
8	Do not use long-term opioid therapy in patients with untreated substance use disorders.
9	Avoid concurrent use of opioids and benzodiazepines. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.
10	Check the Arizona Controlled Substances Prescription Monitoring Program before initiating an opioid or benzodiazepine, and then at least quarterly.
11	Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes prior to prescribing opioids to women of reproductive age.
12	If opioids are used to treat chronic pain, prescribe at the lowest possible dose and for the shortest possible time. Reassess the treatment regimen if prescribing doses ≥50 MEDs.
13	Counsel patients who are taking opioids on safety, including safe storage and disposal of medications, not driving if sedated or confused while using opioids and not sharing opioids with others.
14	Reevaluate patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors and psychiatric comorbidities through face-to-face visits, PDMP checks and urine drug tests.
15	Assess patients on long-term opioid therapy on a regular basis for opioid use disorder and offer or arrange for medication-assisted therapy (e.g. methadone and buprenorphine) to those diagnosed.
16	Offer naloxone and provide overdose education for all patients at risk for opioid overdose.
17	Individualize a careful exit strategy from the use of long-term opioid therapy for chronic pain, when indicated by a risk assessment.

ARIZONA LAWS + RESOURCES

ARIZONA OAR LINE 24/7 CONSULTATION SERVICES

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

The Arizona OAR Line (Opioid Assistance & Referral Line)
https://azpoison.com/news/arizona-oar-line

DESCRIPTION:

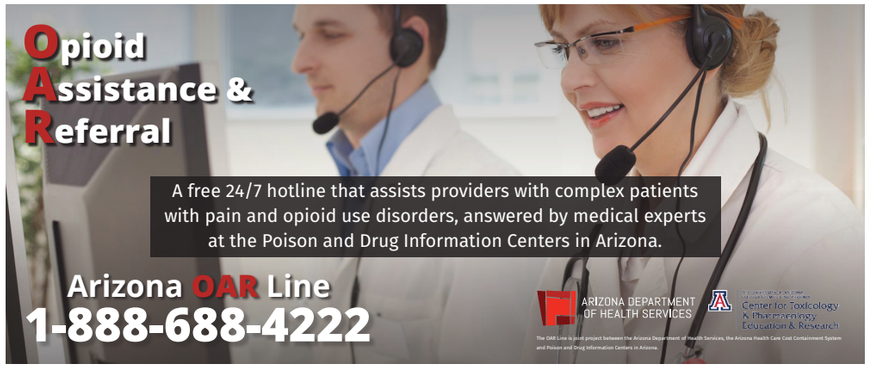
The Arizona OAR Line is one of the country's first real-time, comprehensive opioid hotlines for healthcare providers seeking consultation for complex patients with pain and opioid use disorder. OAR Line protocols are consistent with the *2018 Arizona Opioid Prescribing Guidelines* and can provide assistance on tapering and other exit plans, potentially dangerous drug combinations and chronic pain treatment options, and can also assist with the diagnosis of opioid use disorder. OAR Line Provider Support Services include advising on:

- Patients taking high numbers of MME
- 90 MME new prescription physician consultation
- Patients that require an exit strategy from their current opioid regimen (including tapering)
- New patients on multiple controlled substances
- Patients with challenging pain and mental health/substance use comorbidities
- Patients with acute opioid overdose or toxicity
- Patients with acute opioid or benzodiazepine withdrawal
- Patients that require MAT
- Patients that require local referrals to behavioral health or substance use disorder treatment
- [Note: The OAR Line does not provide CSPMP support.]

As a further service, the OAR Line offers referral and follow-up services to the public, including answering questions about drug combinations and dosages. They can also assist in finding treatment locations for opioid use disorder.

HOW TO USE:

The 24/7 hotline is 888-688-4222, and is operated by Arizona's Poison and Drug Information Centers.



ARIZONA BEHAVIORAL HEALTH RESOURCES

Governor's Office of Youth, Faith and Family

SAMHSA Substance Abuse and Mental Health Services Administration

AHCCCS Arizona Health Care Cost Containment System

NA

EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES

RESOURCE

Substance Use Disorder Treatment Locators
findtreatment.gov
findtreatment.samhsa.gov
https://substanceabuse.az.gov/
https://www.azahcccs.gov/Members/BehavioralHealthServices/OpioidUseDisorderAndTreatment/Locating_Treatment.html
https://www.azahcccs.gov/Members/Downloads/AccessingBHSystem.pdf
https://arizona-na.org/

DESCRIPTION:

It is challenging to find an up-to-date resource of addiction and behavioral health specialists in Arizona. Included below are four links for addiction treatment providers, one link to narcotics anonymous, and one link to AHCCCS behavioral health. It is likely that the first link listed is the most up-to-date.

1. www.FindTreatment.gov. This federal tool was launched on October 30, 2019 and helps individuals to find substance use treatment for themselves or others. Treatment facilities can be sorted by the type of treatment they offer, including treatment for co-occurring mental illness and substance use and telemedicine care that can be accessed virtually.
2. www.FindTreatment.samhsa.gov. This is the original federal treatment locator tool, and is a confidential and anonymous source of information for persons seeking treatment facilities in the US. There are other treatment program locators to find programs providing buprenorphine or methadone for opioid addiction.
3. www.Substanceabuse.az.gov. This Arizona-based tool has not been updated for a few years, but can be used as a starting point for finding treatment locations within the state.
4. www.azahcccs.gov/Members/BehavioralHealthServices/OpioidUseDisorderAndTreatment/Locating_Treatment.html. This is the AHCCCS website that shows the locations for the six Access Point locations providing opioid treatment services 24/7.
5. www.azahcccs.gov/Members/Downloads/AccessingBHSystem.pdf. This is an AHCCCS flow chart (also included below) that is a flow chart of finding behavioral health providers in Arizona.
6. https://arizona-na.org/. This is the Arizona Narcotics Anonymous website that has a listing of home groups and meetings within Arizona.

HOW TO USE:

These websites are a start for getting to know the resources for patients in Arizona. If options still cannot be found, other members of the healthcare team can be requested to call the patient's insurance company to determine where services are covered.

AHCCCS
Arizona Health Care Cost Containment System

DOES THE INDIVIDUAL APPEAR TO BE AN IMMEDIATE DANGER TO HIS/HER OWN SAFETY OR TO THE SAFETY OF OTHERS?
CALL 911

DOES THE INDIVIDUAL APPEAR TO BE IN NEED OF MENTAL HEALTH ASSISTANCE RIGHT AWAY?
SEE CRISIS SERVICES

Accessing/Paying for Behavioral Health

For enrollment in the health insurance marketplace www.healthcare.gov

START HERE
Does the person have health insurance or Medicare?

YES → Contact the health insurance company to get a referral to behavioral health services. Medicare pays 80% of initial visit to behavioral health professionals and 55% of follow- up visits. Locate providers at medicareinteractive.org

NO

For AHCCCS enrollment healthearizonaplus.gov

Is the person enrolled in AHCCCS?

YES → Contact the Regional Behavioral Health Authority or AHCCCS Complete Care Plan in your region of the state (See page 2-Section A)

NO

Does the person have a problem with drugs or alcohol?

YES → Contact the Regional Behavioral Health Authority or AHCCCS Complete Care Plan in your region of the state (See page 2-Section A)

NO

Has this person ever served in the military

YES → Contact the Veterans Administration (VA) in your region of the state to find out if the veteran will qualify for VA funded services:(See page 2-Section B)

NO

Is the person a member of a federally recognized Tribal Nation?

YES → Contact Indian Health Services (IHS) to determine eligibility and receive referral information:

- Navajo Nation 928-871-4811; serving Navajo Nation.
- Tucson 520-295-2405; serving the Tohono O'Odham Nation and Pascua Yaqui Tribe.
- Phoenix 602-364-5039; Alcohol and Substance Abuse: 602-364-5159; Suicide Issues: 602-364-5183; serving all other Arizona Tribal Nations

NO

(See page 2-Section C)

SECTION A

Tribal and Regional Behavioral Health Authorities and AHCCCS Complete Care Plans By Region

Note: latest website and 24-hr line information can be found at www.azahcccs.gov

Tribal and Regional Behavioral Health Authority (TRBHA / RBHA):	County or Tribal Nation Served
Arizona Complete Health-Complete Care Plan www.azcompletehealth.com/completecare and 1-888-788-4408	Gila, La Paz, Pima, Pinal, Yuma, Graham, Greenlee, Santa Cruz, and Cochise
Gila River TRBHA: www.gilariverrbha.org and 1-888-484-8526 ext. 7100	Gila River Indian Community
Mercy Care: www.mercycareaz.org and 1-800-624-3879	Maricopa
Navajo Nation TRBHA: www.nndoh.org/dbhs and 1-866-841-0277	Navajo Nation
Steward Health Choice Arizona: www.StewardHealthChoiceAZ.com and 1-800-322-8670	Apache, Coconino, Mohave, Navajo, Yavapai
Pascua-Yaqui TRBHA: www.pascuayaqui-nsn.gov and 520-879-6060	Pascua Yaqui Tribe
White Mountain Apache TRBHA: www.wmabhs.org and 928-338-4811	White Mountain Apache Nation
ACC Plan	**Geographic Service Area (GSA) Served**
Care1st Health Plan: www.care1staz.com and 1-866-560-4042	North, Central
Steward Health Choice Arizona: www.StewardHealthChoiceAZ.com and 1-800-322-8670	North, Central
Magellan Complete Care: www.mccofaz.com and 1-800-424-5891	Central
Mercy Care: www.mercycareaz.org and 1-800-624-3879	Central
Banner-University Family Care: www.bannerufc.com/acc and 1-800-582-8686	Central, South
UnitedHealthcare Community Plan: www.uhccommunityplan.com and 1-800-348-4058	Central, South
Arizona Complete Health-Complete Care Plan: www.azcompletehealth.com/completecare and 1-888-788-4408	Central, South

SECTION B

Veterans Administration (VA) by Region

VA Health Care System	Counties Served
Phoenix: 602-277-5551	Gila, Maricopa
Northern Arizona: 928-445-4860	Apache, Coconino, Mojave, Navajo, Yavapai
Southern Arizona: 520-792-1450	Cochise, Graham, Gila, Greenlee, La Paz, Pima, Pinal, Santa Cruz, Yuma

SECTION C

Additional Resources

Some free or low cost support services may be obtained from sliding fee scale clinics, community organizations, and/or places of worship. Some examples of free or low/cost no cost support services are listed below:

The Arizona Department of Financial Institutions: offer free counseling service to those behind on mortgage payments or facing foreclosure, 877-448-1211. SOS Non Title 19 Resource Hotline: (602) 759-8175.

Transitional Living Centers "TLC": Helping recovering substance abusers rebuild their lives since 1992 www.transitionalliving.org.

Family Involvement Center "FIC": Select "Services" then "Classes/Support Groups" http://www.familyinvolvementcenter.org. NAMI AZ: Select your local affiliate and select "Support Groups" www.namiaz.com.

MIKID AZ: Select "Programs and Services" and select "Family Support" www.mikid.org/.

Stand Together and Recover (STAR) Centers: Peer Support and Recovery Centers: www.thestarcenters.org.

Substance Use Support:

- National Drug and Alcohol Referral Routing Service: 1-800-662-HELP (4357), press "2" for Spanish or: http://findtreatment.samhsa.gov.
- Alcoholics Anonymous (AA) meeting locator: http://www.area03.org/AA-Meetings.
- Narcotics Anonymous (NA): 1-818-773-9999; online arizona-na.org.

Suicide Prevention Resources:

- National Suicide Prevention Lifeline: 1-800-273-TALK (8255), press "1" for veteran support; online www.suicidepreventionlifeline.org
- National Suicide Prevention Lifeline in Spanish: 1-888-628-9454.
- The Trevor Hotline (Suicide Prevention Hotline for gay and questioning youth): 1-866-488-7386; online www.thetrevorproject.org
- Teen Lifeline: 1-800-248-TEEN (8336); online teenlifeline.org.
- Low cost/no cost support groups: www.mentalhealthamerica.net/find-support-groups.

Rev 11/14/2018

ARIZONA RX DRUG DROP OFF LOCATIONS

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

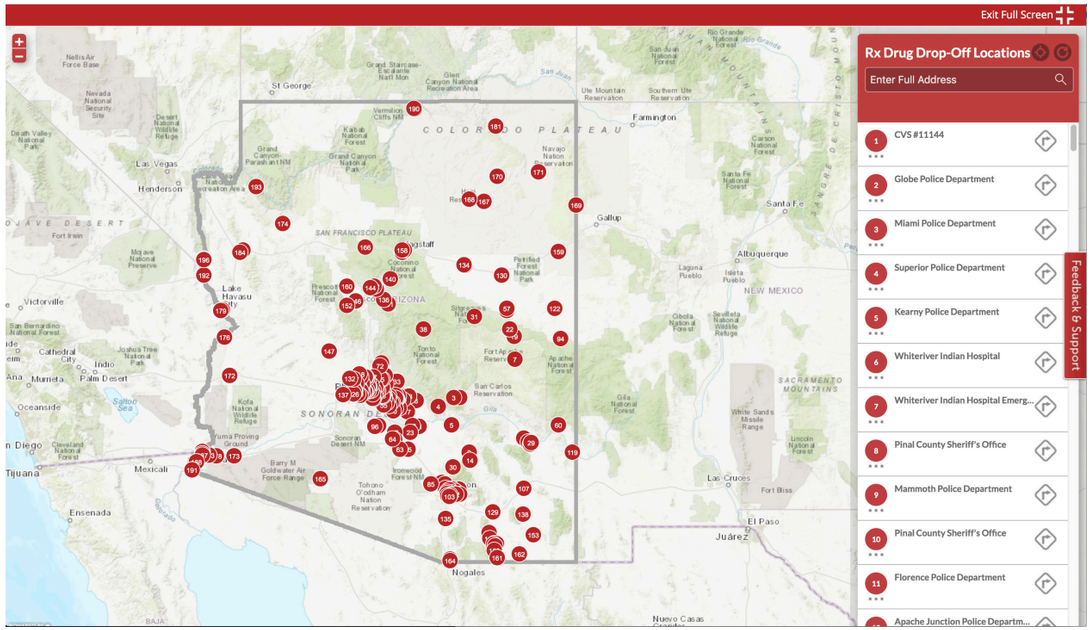
Arizona Rx Drug Drop Off Locations
https://azdhs.gov/gis/rx-drop-off-locations/index.php

DESCRIPTION:

The Arizona Department of Health Services maintains an interactive map with prescription drug drop off locations. Medicine disposal programs like this are a way to remove expired, unwanted, or unused medications from the home and reduce the chance that others may take them.

HOW TO USE:

The healthcare team can search this website to provide nearby drop-off locations for patients, or a team member can provide the URL to patients to find a convenient location for safe medication disposal.



ARIZONA CME + TRAINING

ARIZONA DEPARTMENT
OF HEALTH SERVICES

ARIZONA CME + TRAINING

ARIZONA CME FOR PAIN AND ADDICTION

ARIZONA OPIOID PRESCRIBER EDUCATION
Resources • Response • Recovery

RESOURCE

The Arizona Opioid Prescriber Education Platform
https://www.az-osteo.org/mpage/AzRxEd

DESCRIPTION:

This is a free online continuing medical education program that was developed by a multidisciplinary team of healthcare professionals led by the Arizona Osteopathic Medical Association and Arizona State University College of Health Solutions. This program is for healthcare professionals and provides information about Arizona's opioid laws and regulations, *2018 Arizona Opioid Prescribing Guidelines* and treatment options for opioid use disorder. There is a total of 3 credits available.

HOW TO USE:

There are three modules, each of which is accredited for all types of physicians, nurse practitioners, physician assistants, pharmacists, and optometrists. It is applicable for the mandated three hours of continuing medical education as stipulated in Arizona Revised Statutes §32-3248.02.

ARIZONA OPIOID PRESCRIBER EDUCATION

Resources • Response • Recovery

Are you in compliance with Arizona's opioid laws and regulations? Are you utilizing the best practices for prescribing opioids to patients? Do you understand how Medication Assisted Treatment can help patients?

The Arizona Opioid Prescriber Education platform is a free online continuing medical education (CME) program for healthcare professionals that provides the latest information about Arizona's opioid laws and regulations, prescribing guidelines, and treatment options for opioid use disorder. The education modules were developed by a multidisciplinary team of healthcare professionals led by the Arizona Osteopathic Medical Association and presented through an interactive, user-friendly, e-learning system by the Arizona State University, College of Health Solutions.

Each education module is accredited for all types of physicians, nurse practitioners, physician assistants, pharmacists, and optometrists and is applicable for the mandated three hours of continuing medical education as stipulated in Arizona Revised Statutes 32-3248.02. Each module requires a separate log in and basic information to get started.

*Please note: Chrome is the preferred browser to take these courses. You will need a desktop or laptop computer to access courses. A mobile device will not provide the access and functionality necessary for these online courses.

- 1.5 *AMA PRA Category 1 Credits™*
- 1.5 AOA Category 1-B Credits
- 1.5 contact hours (0.15 CEUs) of continuing pharmacy education credit

- 1.0 *AMA PRA Category 1 Credit™*
- 1.0 AOA Category 1-B Credit
- 1.0 contact hours (0.10 CEUs) of continuing pharmacy education credit

- .5 *AMA PRA Category 1 Credit™*
- .5 AOA Category 1-B Credit
- .5 contact hours (0.05 CEUs) of continuing pharmacy education credit

Release Dates:

AMA PRA Category 1 Credits™	June 1, 2019
AOA Category 1-B Credits	June 1, 2019
ACPE Continuing Pharmacy Education Credits	June 1, 2019

ARIZONA CME + TRAINING

ARIZONA CME FOR PAIN AND ADDICTION

RESOURCE

Opioid Prescribing CME Courses
https://www.vlh.com/azprescribing

DESCRIPTION:

This is a free online continuing medical education program developed by the University of Arizona College of Medicine to help Arizona prescribers incorporate into practice the *2018 Arizona Opioid Prescribing Guidelines*. Learners will manage virtual patients in the following courses: 1) Introduction to Safe Prescribing of Opioids for Pain Management 2) Safe and Effective Opioid Prescribing While Managing Acute and Chronic Pain 3) Managing Opioid Misuse Disorder in Pregnancy and Neonatal Care. There is a total of 4 credits available.

HOW TO USE:

There are four modules, each of which offers AMA PRA Category 1 Credit.

Opioid Prescribing CME Courses: Responding to the Public Health Emergency

A series of online courses offering free *AMA PRA Category 1 Credit™* to help Arizona prescribers incorporate into practice the **Arizona Opioid Prescribing Guidelines.**

CLICK HERE to Get Started and Register Your Free Account

There is increasing evidence that opioid medications are over-prescribed and poorly managed because prescribers are not aware of appropriate opioid risk management strategies and non-opioid approaches to treating chronic pain. These activities seek to familiarize prescribers with current guidelines for opioid use and prescribing, as well as educate prescribers about non-opioid strategies for pain management.

Learning Objectives

1. Appropriately utilize a range of therapeutic options when managing patients with acute and chronic non-terminal pain.
2. Comply with current opioid risk-management practices, including the use of pain contracts and urine drug testing.
3. Educate patients on the proper use, storage, and disposal of opioid medications.
4. Use preferred modalities and medications for the treatment of acute and chronic non-terminal pain.
5. Assess when it would be appropriate or not for a pregnant patient to undergo medically-supervised withdrawal from heroin.
6. Determine the initial post-delivery treatment plan for an infant exposed to maternal methadone during pregnancy.

Learners will manage virtual patients in the following courses:

Introduction to Safe Prescribing of Opioids for Pain Management

Safe and Effective Opioid Prescribing While Managing Acute and Chronic Pain

Managing Opioid Misuse Disorder in Pregnancy and Neonatal Care

Opioid Issues in Youth Pain Management for Orthopedic Injuries

All courses offer *AMA PRA Category 1 Credit™.*

Developed in Partnership with:
- Arizona Prescription Drug Misuse & Abuse Initiative
- Arizona Department of Health Services
- University of Arizona College of Public Health
- University of Arizona College of Medicine

Supported by CDC Grant Number 1U17CE002717-01 and by a grant from the Arizona Governor's Office for Youth, Faith, and Families (ADHS14-067194:1).

ARIZONA CME + TRAINING

ARIZONA BEYOND ADDICTION TELEMENTORING PROGRAM

THE UNIVERSITY OF ARIZONA | COLLEGE OF MEDICINE

RESOURCE

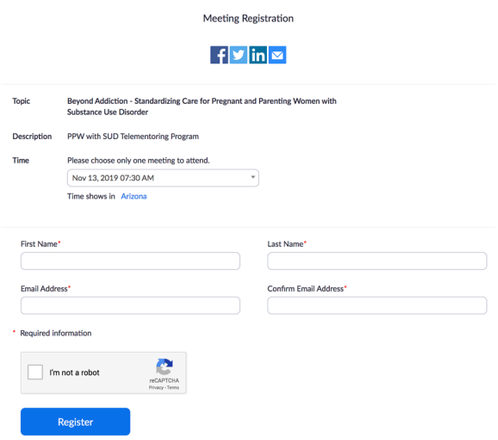
Beyond Addiction Telementoring Program (UA College of Medicine – Phoenix)
http://bit.ly/BeyondAddictionTelemedicine
http://bit.ly/BeyondAddictionRegistration

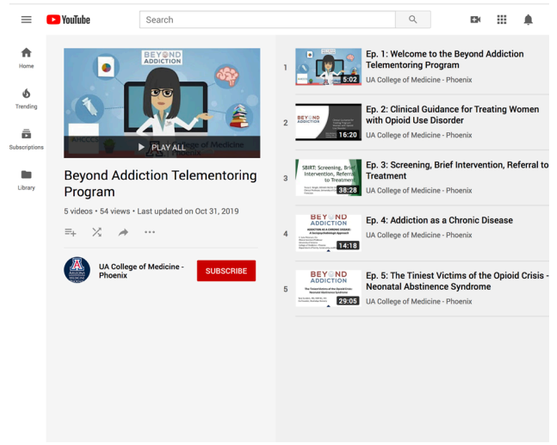
DESCRIPTION:

Sponsored by a grant from AHCCCS, this set of telementoring videos from the UA College of Medicine shares the latest in evidence-based practice and expert experiences concerning health outcomes in pregnant and parenting women with substance use disorder. It will also include a focus on the components on *The Arizona Pain and Addiction Curriculum*.

HOW TO USE:

Sessions are uploaded to YouTube and can be viewed at any time. CME credit will only be offered to participants of the live broadcast sessions.





CLINIC FORMS + SYSTEM-BASED RESOURCES

ARIZONA DEPARTMENT
OF HEALTH SERVICES

SAMPLE HEALTHCARE SYSTEM POLICIES FOR OPIOID THERAPY

RESOURCE

Toolkit: Examples of Local Healthcare System Policies
https://www.naccho.org/uploads/downloadable-resources/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

DESCRIPTION:

This one-pager toolkit is a bulleted list of example policies for healthcare systems for managing and coordinating long-term opioid therapy. It comes from the CDC's companion document of how to implement the CDC Guidelines.

HOW TO USE:

This list can be browsed through and bullets can be selected or adapted for the particular healthcare policy. Policies can be important drivers of clinical decision-making and behavior.

Toolkit Part B.

Examples of Local Healthcare System Policies

- **The following are examples of policies for managing and coordinating long-term opioid therapy:**
  - The practice develops an administrative definition of long-term opioid therapy to enable identification of long-term opioid therapy patients (e.g. receiving at least 70 days' supply of opioids in a 90-day period).
  - The practice develops an administrative definition to identify patients potentially transitioning into long-term opioid use (e.g., filling a third opioid prescription within six months when not identified as a long-term opioid therapy patient).
  - Long-term opioid therapy patients receiving daily doses in excess of 90 Morphine Milligram Equivalent (MME) should have their opioid regimen reviewed by a pain and/or rehabilitation medicine specialist.
  - Providers obtain signed, informed consent from patients initiating long-term opioid therapy.
  - The practice will not refill lost or stolen opioid prescriptions except in extraordinary circumstances.
  - A standard advance notification period (e.g., 4 days) prior to receiving an opioid refill is required.
  - A standard monthly refill will be for 28 days, so refills can be picked up on the same day of the week, avoiding refills that fall on a weekend.
  - Guidance for appropriate duration of opioid prescriptions (e.g., 3-7 days) for managing common acute pain conditions.
  - The practice will not provide opioid pain medicines to long-term opioid therapy patients already getting opioids from other healthcare providers.
  - Patients on particularly high-dose opioids (e.g., 200 MME) have their use reviewed by a pain medicine specialist every month.
  - The practice checks the prescription drug monitoring program (PDMP) periodically for patients receiving long-term opioid therapy, ranging from every prescription to every three months.
  - All long-term opioid therapy patients must sign or review an opioid treatment agreement and informed consent form, which is placed in the medical record.
  - Providers use standardized forms and templates in the electronic health record (EHR) for managing long-term opioid therapy patients.
  - Patients receiving long-term opioid therapy have urine drug tests every 12 months.
  - Providers must assess the functional status, quality of life, and pain intensity in all patients receiving long-term opioid therapy at baseline and follow-up visits, using a standard scale (e.g., PEG).
  - The practice will educate and engage the patient in order to ensure effective pain management.
  - Patients receiving long-term opioid therapy are expected to concurrently use nonopioid therapies and self-care management strategies to increase engagement in life activities and enhance quality of life.

CLINIC FORMS + SYSTEM-BASED RESOURCES

SAMPLE CLINICAL POLICY FOR NEW PATIENTS

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

RESOURCE

Sample Clinical Policy for New Patients and Prescribing of Controlled Substances
http://www.med.umich.edu/1info/FHP/practiceguides/pain/policy.pdf

DESCRIPTION:

This is a sample clinical policy concerning the prescribing of controlled substances for new patients. It states that before the first prescription from a clinician, the clinic record must contain a) the medial records, b) urine comprehensive drug test c) PDMP search results and if long-term use is anticipated d) a completed controlled substance contract.

HOW TO USE:

This document can be used as an example when creating a policy in a healthcare facility or clinic. Clinics can individualize their policy and may elect to include elements such as not providing a refill for a controlled substance at a patient's first visit, or not before having prior medical records.

Example Clinical Policy

Clinic Policy Regarding Patients on Long-term Controlled Substances
(opioids, benzodiazepines and stimulants)

New Patients with a History of Long–term Use of a Controlled Substance

Before a new patient with a history of long-term controlled substance prescription use receives the first prescription from a clinic physician, our clinic record must contain: the medical records, urine comprehensive drug scan, MAPS search results and, if long term use is anticipated, a completed controlled substance contract.

Medical records. These new patients must provide medical records documenting previous medical work-up regarding the complaint necessitating these prescriptions and notes from previous physicians that prescribed these medications.

Obtain relevant medical records from previous providers. The patient is responsible for having this information sent. This clinic will provide to the patient forms for release of information along with the fax number and mailing address of our clinic. The previous physician's office should send the information directly to this clinic. This clinic will also provide to the patient the clinic phone number to verify that the patient's medical records have been received and to make appointments.

The Initial clinic note should follow the suggested format outline and must be complete for elements of the Past, Family and Social histories that could put a patient at risk for medication problems. It should include a detailed prescription history (last time/date controlled substance taken).

Urine comprehensive drug screen ("DRUG COMP"). DRUG COMP is combined immunoassay screening and gas chromatography/mass spectroscopy that together detect specific synthetic opioids along with morphine/codeine, benzodiazepines and drugs of abuse such as amphetamines, THC, and cocaine It will also detect many common prescription meds such as tramadol, cyclobenzaprine, and TCAs. (A SAMHSA Drug 5 or Drug 6 immunoassay screen is inadequate due to difficulty of interpretation and problems with false positives and negatives.)

Order a DRUG COMP screen for all new patients. To avoid false negatives, inform the lab in the test order if a specific opioid should be present (particularly methadone, fentanyl and buprenorphine).

DRUG COMP specimen is collected in the clinic. Patients should not wear coats and other outer clothing or take purses, bags, backpacks into the bathroom. The nurse or provider should confirm promptly that the specimen is appropriately warm and should send it directly to the lab, not give it to the patient to deliver.

Check consistency between screen results and patient history and that no illicit drugs are present.

Michigan Automated Prescription System (MAPS). Search the state's online database of prescription fills controlled substances
(MAPS: https://milogintp.michigan.gov/eai/tplogin/authenticate?URL=/) for the patient's filling history. Physicians should register at https://milogintp.michigan.gov/uisecure/tpselfservice/anonymous/register .)
Controlled Substance Contract/Informed Consent – long term use. At the visit when the first prescription is provided for a controlled substance, if long term use is anticipated the provider should initiate with the patient completion of the clinic's controlled substance contract/informed consent. The completed contract is scanned to the medical record, labeled "Controlled Substance Contract," and noted on the Problem List in the PSL (Problem Summary List).

Established Patients Using a Controlled Substance

Use the attached Established Patient Visit Checklist (copy also in the UMHS Chronic Pain guideline).

New patient criteria. All established patients must meet the above criteria for new patients.

Lost prescriptions: No lost prescriptions will be replaced.

Early refills. No early refills will be given.

Pill counts with urine screen. Ask the patient to bring existing pill bottles (with remaining pills, for a pill count) and submit a urine comprehensive drug screen (DRUG COMP) in the following situations:
- Twice yearly for all chronic non-malignant pain patients receiving opioids – once during January-June and another July-December.
- Patient requesting early prescription – for example, "going on vacation, emergency trip out of state", "had to change pharmacies."
- Patient behavior concerning for intoxication by illicit drugs.
- Patient requesting refill on controlled substance we have never prescribed.
- Person other than patient requesting refill or picking up prescription.
- Patient cannot state directions as prescribed for taking medication.
- Patient not permitted to speak with physician alone (other people won't leave examining room).
- Patient's physical exam or history concerning for misuse of controlled substance or illicit drug use.
- Clinic receives information from a pharmacy or other health care provider concerning for patient obtaining controlled substances from multiple physicians.

Problem results of urine comprehensive drug screen ("DRUG COMP"). (Note: A "Drug 6 immunoassay" screen is inadequate.)
- Diversion – drug screen negative for drugs prescribed. If diversion is suspected, prescribing controlled substances is *illegal*. No prescription will be provided by any member our practice. A repeat test must be completed within 48 hrs.
- Multiple sources – drug screen positive for controlled substances not being prescribed by our practice. The patient appears to be receiving opioids from multiple physicians. Members of our practice will not continue to prescribe controlled substances for these patients.
- Illegal/illicit drugs– positive screen. Absolutely no controlled prescription will be prescribed. Controlled substances cannot be safely prescribed in patients taking illicit drugs, *including cannabis*.

Disorderly behavior in clinic. Abusive behavior toward clinic staff, or disruptive behavior interfering with the care of other patients will not be tolerated. Call a "yellow card" for any threatening behavior. The patient may be dismissed from our clinic permanently.

Terminate controlled substance prescriptions. The following patient behaviors will result in terminating these prescriptions. Note termination of controlled substances in the CareWeb PSL.
- Fails to comply with drug testing as requested, including second follow-up test in timely manner
- Fails to comply with medical evaluation of pain complaint: diagnostic tests requested (e.g., radiology tests, EMG, stress test) and referrals (e.g., neurology, neurosurgery, physical or occupational therapy, pain specialist/anesthesia, psychology or psychiatry).
- Does not report treatment with opioids/controlled substances by other physicians
- Has drug testing results not consistent with clinic physician's prescription plan:
  - Prescriptions patient reports taking daily are not detected on screen.
  - Patient tests positive for controlled substances not prescribed by clinic.
  - Patient tests positive for illicit substances, particularly cocaine – patients should be referred for drug treatment.
- Misses more than two appointments (no show) per year without proper cancellation

Visit Checklist for Established Patients on Long-term Controlled Substances

- ☐ Determine level of adherence to both pain and general medical management plans (medications, physical therapy, lifestyle interventions, etc.).
- ☐ Document progress toward functional goals and pain response.
- ☐ Evaluate for adverse effects of medications (NSAIDs, adjuvants, opioids)
- ☐ Assess for 'red flag' drug-taking behavior. Review written pain management agreement for patients at risk.
- ☐ Check MAPS quarterly.
- ☐ Order a urine comprehensive drug screen ("DRUG COMP") on all patients twice per year – once during January-June and another July-December,
- ☐ Review management plan: refine functional goals, titrate effective medications, stop ineffective medications (including NSAIDs and opioids), modify non-interventional modalities, review expectations.
- ☐ Assure that a Treatment Agreement (Contract) is scanned to the record, labeled "Controlled Substance Contract" and noted on the PSL Problem List.
- ☐ Evaluate for appropriate boundaries in therapeutic relationship.
- ☐ Consider referral to Comprehensive Pain Management Center for evidence of addiction behavior, failure to reach functional goals despite adherence to plan, rapidly escalating or very high dose opioid needs, or poor psychological adjustment to symptoms.

CLINIC FORMS + SYSTEM-BASED RESOURCES

SAMPLE OPIOID TREATMENT AGREEMENT

RESOURCE

Toolkit: Sample Opioid Treatment Agreement
https://www.naccho.org/uploads/downloadable-resources/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

DESCRIPTION:

This CDC Toolkit, part of the guidance for implementation of their guidelines, provides examples of treatment agreements for opioid therapy. It comes with potential talking points to discuss with patients as part of the treatment agreement conversation.

HOW TO USE:

Before initiating long-term opioid therapy, patients should complete a treatment agreement and provide informed consent. The treatment agreement included above can be used and adapted for the particular healthcare setting and treating provider. There are several other sample agreements that the CDC includes at the webpage above.

Example of a Treatment Agreement

Patient name: _____ MR#:_____

[Name of Clinic]

Pain Medicine and Other Controlled Substances Agreement

This agreement is for patients who are prescribed certain pain medicines called opioids and other "controlled substances." These medicines are sometimes called narcotics.

This agreement pertains to the following list of your medicine(s).

1 _____
2 _____
3 _____
4 _____

The purpose of this agreement is to describe how you, your physician, and your treatment team will work together to make sure your medicine is used safely and works well to help you.

You and a [clinic] physician will sign the agreement to show you both understand and agree with it. It will be saved in your medical record, so you and your treatment team can look at it again later. You will get a copy to take home.

My pain/symptoms and goals

My pain/symptoms is/are (describe):

_____

What (activities) do I hope to be able to do?

_____

Goals for me are (describe):

_____

I understand the following:

- ☐ My pain/symptoms will probably not go away completely.
- ☐ My medicine may not work for me.
- ☐ The long-term use of opioid pain medicine is controversial.
- ☐ It is important not to miss appointments with my physician.
- ☐ Treating pain/symptoms often includes physical therapy, counseling, and/or other treatments.
- ☐ I will try additional treatments that my physician suggests.
- ☐ Increasing my participation in family, social, and/or work activities is part of my treatment program, which can make pain less bothersome.

Risks and safer use of controlled substances

Using this medicine might cause problems like:

- ☐ addiction ☐ allergic reactions ☐ breathing problems ☐ sleep apnea
- ☐ constipation and/or upset stomach
- ☐ dangerous driving and/or being charged with DUI
- ☐ feeling sleepy, dizzy, or confused
- ☐ overdose or death—especially if taken with alcohol or other drugs, or if I take more than my doctor prescribes
- ☐ problems urinating, problems with erections, reduced testosterone levels
- ☐ worse pain or feeling sick if I stop my pain medicine suddenly

I will:

- ☐ only get my medicine from my physician, Dr._____, or a covering doctor at this office if my physician is not available. If any other physicians prescribe pain medicine or other controlled substances for me in an emergency, I will let my [clinic name] physician know as soon as possible.
- ☐ call my nurse, _____, between the hours of 9 a.m. to 5 p.m. Monday through Friday with any questions or concerns about my pain/symptoms or medications.
- ☐ only get the medicine(s) listed here from one pharmacy:_____

  Phone number: _____

I will:

- ☐ be honest and open with my physician and members of my treatment team about medicines and drugs I am taking, including over-the-counter medications and illegal drugs.
- ☐ talk to my physician if I feel I need more medicine than was prescribed, but I will not change it on my own or take pain medicine from other people.
- ☐ talk to my physician if I stop or would like to stop the medicine(s) listed here.
- ☐ never give or sell any of my medicine to anyone else.
- ☐ always keep my medicine in a safe place AND away from children and other people who come to my home.
- ☐ allow my doctor to check my urine to see what medicines or drugs I am taking.
- ☐ bring all of my unused medicines in their pharmacy bottles to my office visits if my doctor asks me.

My physician will:

- ☐ work with me to find the best treatment for my pain/symptoms.
- ☐ be honest and open with me about my pain/symptom treatment.
- ☐ ask me about problems caused by my medicine and treat these effects.
- ☐ make sure my medicine is refilled on time.
- ☐ refill my medicine during a visit.
- ☐ allow my nurse to refill my medicine if I don't have a scheduled appointment, and I will call at least 4 days before I run out of medicine.
- ☐ arrange for a covering physician at the clinic to refill my medicine when my physician is not available.
- ☐ will not provide extra refills if my medicine or prescription is lost, stolen, destroyed, misplaced, or if I run out earlier than expected.

Stopping and changing medicine (should involve provider-patient partnership and consent):

- ☐ My physician will stop or change my medicine if:
  - my goals are not being met, OR
  - I do not follow this agreement, OR
  - my physician thinks my medicine may be hurting me more than it is helping me.
- ☐ My physician might refer me to a specialist for treatment of pain/symptoms or drug problems.
- ☐ If my physician believes I have stolen or forged prescriptions, I sell my medicine, or if I threaten or act violently in any way, I will no longer be prescribed controlled substances from this clinic.

I have been able to ask questions about this agreement, and I understand and agree with what it says.

Patient signature: _____ Date: _____

Physician signature: _____ Date: _____

Source: Adapted from a form used with permission of Dr. Jessica Merlin, Assistant Professor, Division of Infectious Diseases, Division of Gerontology, Geriatrics, and Palliative Care, University of Alabama at Birmingham.

CLINIC FORMS + SYSTEM-BASED RESOURCES

SAMPLE CHECKLIST FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

RESOURCE

CDC Checklist for Prescribing Opioids for Chronic Pain
https://www.cdc.gov/drugoverdose/pdf/pdo_checklist-a.pdf

DESCRIPTION:

This is a sample checklist for providers, listing what to do when a) prescribing long-term opioid therapy b) renewing a prescription without a patient visit c) reassessing at the return visit.

HOW TO USE:

This can be used as a model for creating a checklist for use when prescribing long-term opioid therapy (either prior to initiating or at follow-up visits). This checklist from CDC includes an evaluation for adverse effects, assessment for a substance or opioid-use disorder, check of the PDMP and urine drug screens, check that non-opioid therapies are optimized, and reevaluation of the risks and benefits of opioid therapy.

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS273808A

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

CLINIC FORMS + SYSTEM-BASED RESOURCES

PROPUBLICA AND CMS OPEN PAYMENT

RESOURCE

Dollars for Docs, Propublica
https://projects.propublica.org/docdollars/

Open Payment, Centers for Medicare and Medicaid Services
https://www.cms.gov/openpayments/

DESCRIPTION:

Pharmaceutical and medical device companies are required by law to release details of their payments to a variety of doctors and U.S. teaching hospitals (for promotional talks, consulting, research, etc).

The Propublica website can be used to search for general payments made from August 2013-2018, and older data can be found in their linked archive.

The Open Payments website is a national disclosure program that promotes "a more transparent and accountable health care system by making the financial relationships between manufacturers and purchasing organizations and health care providers available to the public." The search tool can look up doctors, hospitals or companies.

HOW TO USE:

Providers are often advised to be aware of financial incentives driving clinical recommendations. These websites can help providers become aware of pharmaceutical and device payments received by educators, consultants, and themselves.

CLINICAL RESOURCES FOR CHRONIC PAIN

ARIZONA DEPARTMENT
OF HEALTH SERVICES

CLINICAL RESOURCES FOR CHRONIC PAIN

UNDERSTANDING PAIN VIDEO (EDUCATION)

RESOURCE

Understanding Pain Video
https://vimeo.com/137163303

DESCRIPTION:

Based on an Australian concept for pain education, Understanding Pain is a 5-minute video that was developed by the VHA Joint Pain Education Project to provide individuals, family members and clinicians with general strategies for managing acute and chronic pain.

HOW TO USE:

This is accessible on Vimeo and other variations are found on YouTube, and is viewing appropriate for patients, students, residents and clinicians.

CLINICAL RESOURCES FOR CHRONIC PAIN

PAIN TOOLKIT WEBSITE (SELF-MANAGEMENT)

RESOURCE

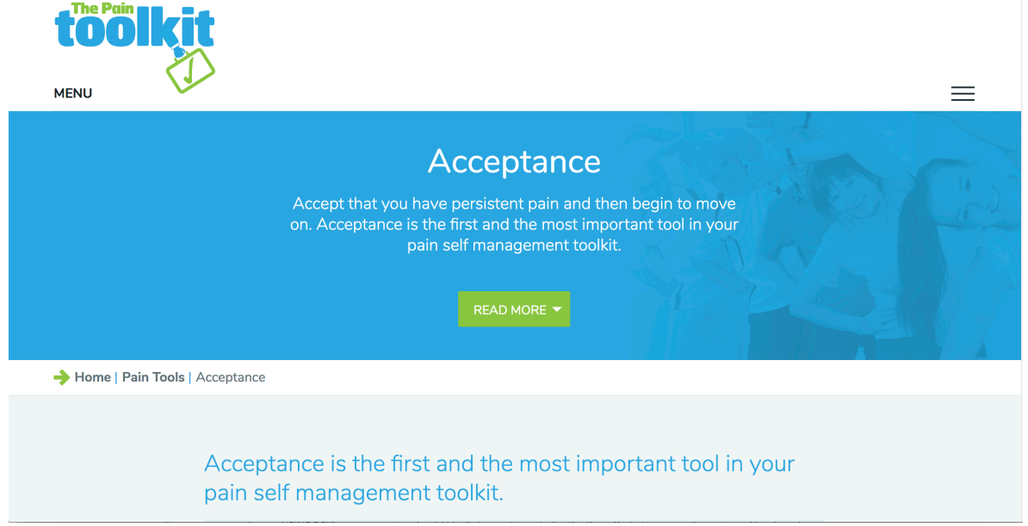
Pain Toolkit Website
https://www.paintoolkit.org/

DESCRIPTION:

This is a set of tools based around the Pain Toolkit (an information booklet) that stresses self-management for pain through tips and skills. It stresses teamwork and partnership with healthcare providers. There are different webpages for each “skill” such as Acceptance, Pacing, Prioritizing, Setting Goals, etc.

HOW TO USE:

This website can be offered to patients when discussing “self-management” and self-efficacy.



CLINICAL RESOURCES FOR CHRONIC PAIN

GUIDE TO AN ANTI-INFLAMMATORY DIET (FOR PATIENTS)

Cleveland Clinic

RESOURCE

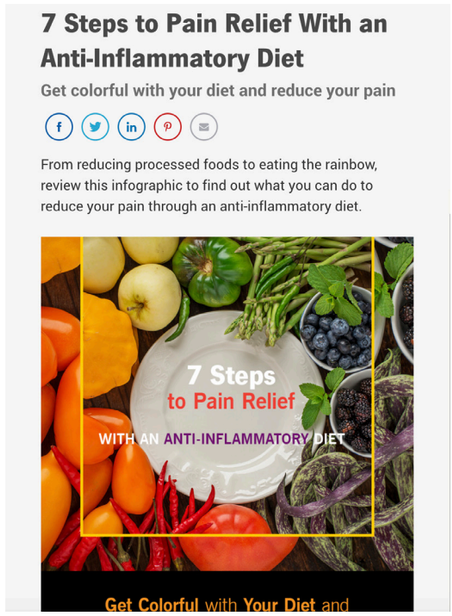
Pain Relief with an anti-inflammatory diet
https://health.clevelandclinic.org/7-steps-pain-relief-anti-inflammatory-diet/

DESCRIPTION:

This is a website for a seven-step plan to pain relief. There are tips and brightly colored images to help show what foods to seek out and what foods to avoid.

HOW TO USE:

This website can be offered to patients as part of a whole-person care plan.



7 Steps to Pain Relief With an Anti-Inflammatory Diet

Get colorful with your diet and reduce your pain

From reducing processed foods to eating the rainbow, review this infographic to find out what you can do to reduce your pain through an anti-inflammatory diet.

CLINICAL RESOURCES FOR CHRONIC PAIN

VA CBT VIDEO VIGNETTES (FOR PROVIDERS)

RESOURCE

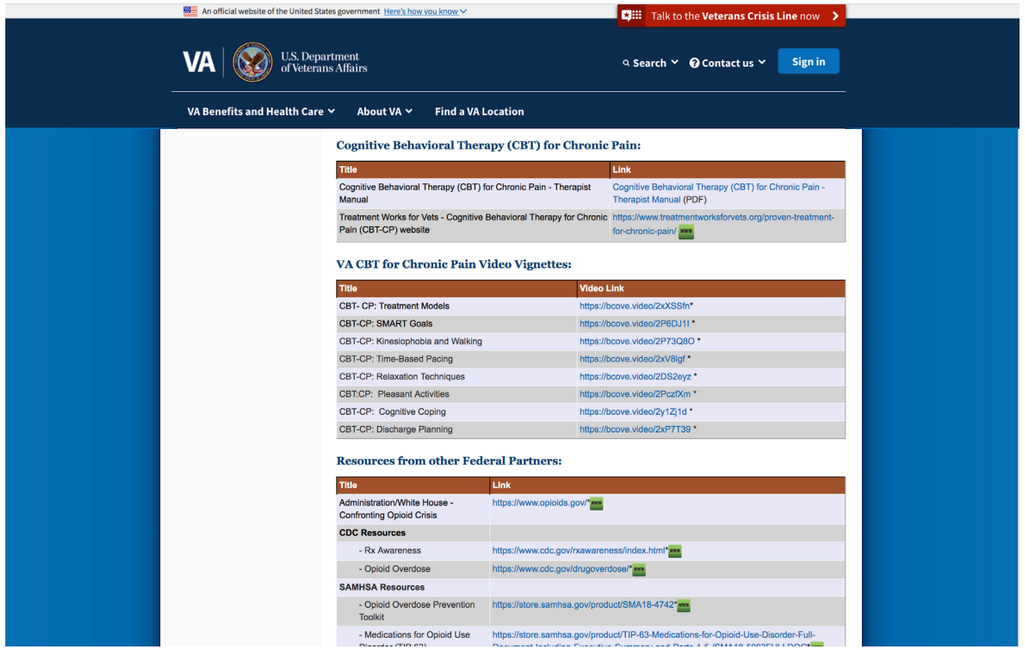
CBT for Chronic Pain Vignettes
https://www.va.gov/PAINMANAGEMENT/Providers/Stay_Current.asp

DESCRIPTION:

This is a set of eight videos of CBT Master Trainers exemplifying their approach for a patient with chronic pain. In the videos, providers explain the complexity of chronic pain, how to set goals with patients, relaxation techniques, cognitive coping and other skills.

HOW TO USE:

The videos are listed halfway down the linked website above and can be used to provide a framework for future discussions with patients.



CLINICAL RESOURCES FOR CHRONIC PAIN

ARIZONA CHRONIC PAIN WEBPAGE (FOR PATIENTS)

ARIZONA DEPARTMENT OF HEALTH SERVICES

RESOURCE

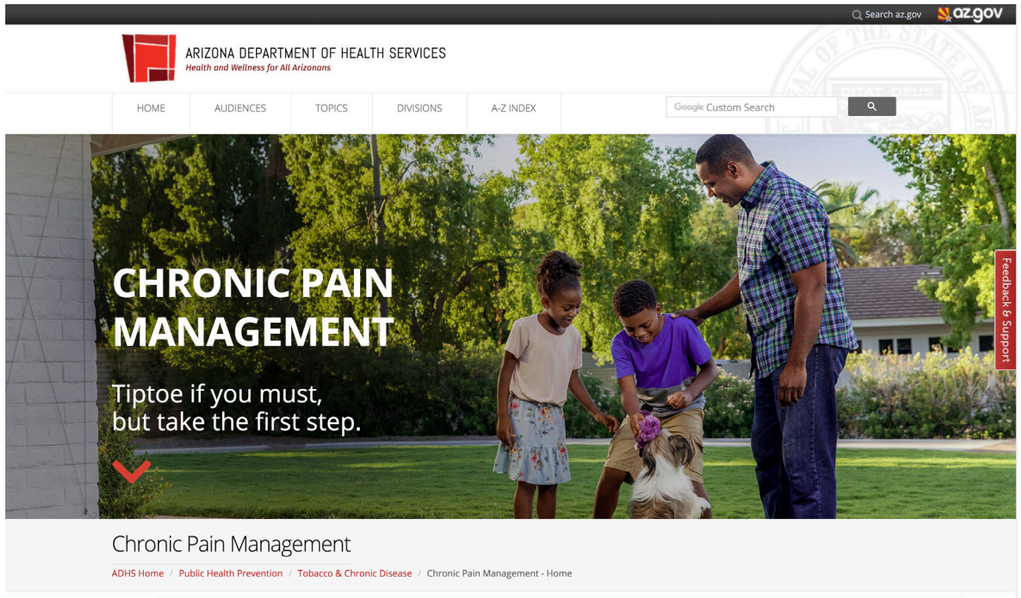
Arizona Department of Health Services Website for Chronic Pain
www.azdhs.gov/chronicpain

DESCRIPTION:

This is a new webpage from the Arizona Department of Health Services, a governmental agency that has approached chronic pain as a public health problem. The material on this website is geared toward patients, and has sections explaining the complexity of chronic pain, along with how to move, eat, manage, feel and connect well. It is activating content that is presented in a straightforward manner and that is consistent with the approach in *The Arizona Pain and Addiction Curriculum*.

HOW TO USE:

This website can be given to patients to explore at home if they or a loved one have chronic pain.



CLINICAL RESOURCES FOR CHRONIC PAIN

HELPFUL TIPS TO GETTING OFF YOUR OPIOID SUCESSFULLY (FOR PATIENTS)

RESOURCE

Patient Guide: Helpful Tips to Getting Off your Opioid Successfully
https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/Pain_Patient_SlowlyStoppingOpioidMedications_101016.pdf

DESCRIPTION:

This is a well-designed product from the VA PBM Academic Detailing Service that is a one-pager (front/back) of helpful tips to slowly stopping opioid medications. It explains the cycle of dependence, expected timing of withdrawal symptoms, and stresses self-care the patient can do while reducing the opioid dose. It is a supportive document.

HOW TO USE:

This handout can be given to patients at any point of planning or executing an opioid taper.

U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Service

Patient Guide

Slowly Stopping Opioid Medications

Helpful Tips to Getting Off Your Opioid Successfully

Is Your Opioid Medication Helping You or Hurting You?

The goal of chronic pain treatment is to help you regain the ability to move and participate in activities that are important to you. Opioid medications may be helpful after an acute injury or surgery but can lose their effect on reducing pain over time. This could keep you from reconnecting with what is important to you. It is time to discover a different way to treat your pain. Talk to your provider about alternatives to opioids and how to safely reduce your opioid medications.

What is an Opioid?

Opioids are a type of pain medication. Common opioids include:

- **Morphine**
- **Oxycodone**
- **Hydrocodone**
- **Methadone**
- **Hydromorphone**
- **Fentanyl**

Possible Risks of Opioids

- **Feeling tired or drowsy**
- **Constipation**
- **Memory problems**
- **Worse pain**
- **Sexual health problems**
- **Falls and accidents**
- **Overdose or addiction**

What concerns do you have about taking opioid medications?

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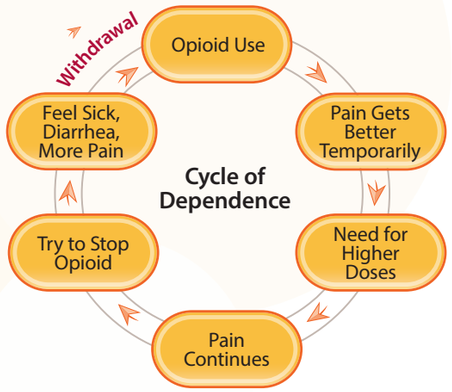


How Will You Feel While Slowly Reducing Your Opioid Medication?

If you have been taking opioids for longer than a few months, your body is used to taking them. Stopping it quickly can cause withdrawal symptoms like:

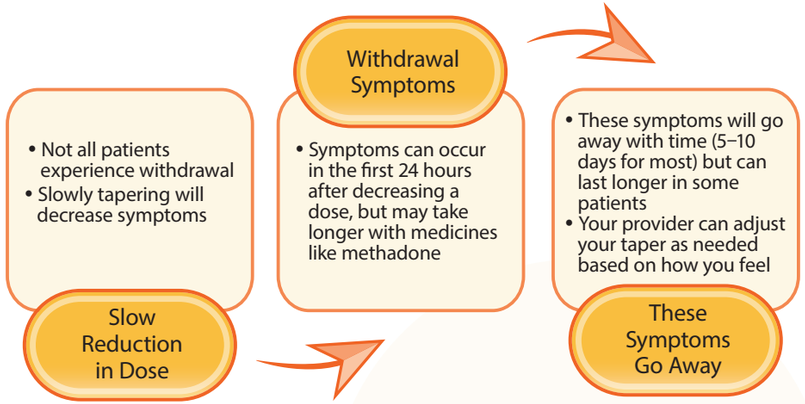
- Muscle aches
- Restlessness
- Anxiety
- Worsening pain
- Difficulty sleeping
- Craving for the opioid
- Diarrhea, abdominal cramping, nausea, vomiting

To keep you from having these withdrawal symptoms, your provider will **very slowly reduce the opioid dose**. This will minimize the discomfort you experience. If you experience any of these symptoms, notify your care team and they can help. Withdrawal symptoms usually only last for a short period.

Once you start reducing the opioid dose, do not take extra doses or try going back to your original dose without talking to your provider. Your body may no longer be used to the higher dose. Taking more opioids can put you at risk for an overdose.

August 2017 IB 10-1016, P96884

Time of Withdrawal



Self-Care You Can Do While Reducing the Opioid Dose

- Participate in wellness activities: meditation, relaxation, prayer.
- Focus on deep breathing: sit in a quiet place with eyes closed and deeply breath in and out.
- Work closely with your provider and report symptoms of withdrawal and craving for the opioid.
- Enlist support from friends and family; consider joining a support/recovery group.
- Know that withdrawal is temporary and while it may be uncomfortable, it is not life-threatening.
- Stopping opioid medications may improve your pain and allow you to be more active.
- If your pain remains a problem, ask your primary care provider for help.

****Do not stop taking any medications without first speaking to your provider****

If you have a strong desire to take more opioids, cannot take your mind off opioids, or find it difficult to take opioids as prescribed, it is important to talk with your provider.

Tapering Schedule:

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Please call _____ with any questions or concerns.

Veterans Crisis Line
1-800-273-TALK (8255) or Text - 838255

VA PBM Academic Detailing Service www.va.gov