



Work Loss Data Institute
 "The Evidence-Based Guideline Company"

Just the facts on Opioid Management

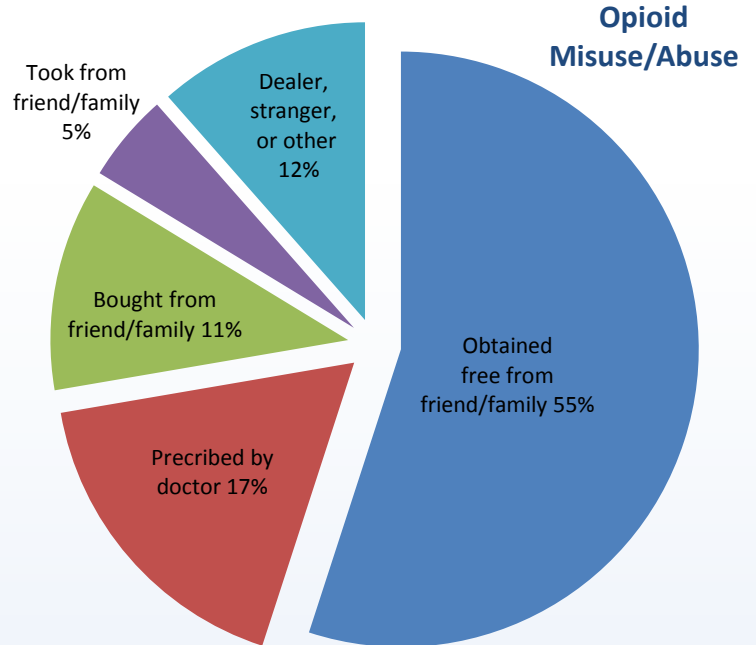
Prudent Prescription Practice Using Evidence-Based Medicine (EBM)

Think twice about the risk of misuse versus medical necessity with each script:

Almost 90% of prescription painkiller misuse and abuse comes from drugs prescribed legally to users or their friends and family. Most of the prescriptions come from primary care and internal medicine doctors, not specialists.

Healthcare provider accountability:

The Centers for Disease Control has urged States to ensure providers follow evidence-based treatment guidelines for the safe and effective use of prescription painkillers.



EBM Takeaways from Official Disability Guidelines (ODG)

Acute Pain

Not recommended except for short-term use for severe cases, not to exceed two weeks. Patients should be warned of risks and side effects.

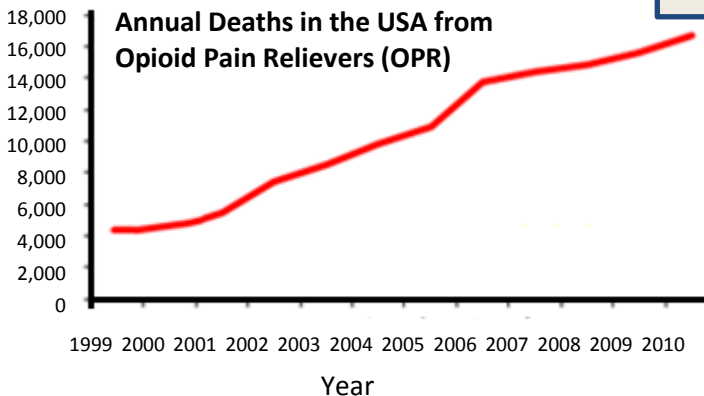
Subacute Pain

Increasing duration of use may lead to dependency and higher prevalence of work disability, depression, anxiety, and substance abuse.

Chronic Pain

Recommended only as 2nd/3rd line option at doses ≤ 120 mg daily oral morphine (MED) equivalent in cases not at risk of misuse or diversion.

Routine long-term opioid therapy for non-malignant pain is NOT recommended. Evidence does not support overall effectiveness and indicates risk of numerous adverse effects, including psychological dependence with difficulty weaning.



OPR deaths now far exceed those from heroin/cocaine. Overdose and death risk increases significantly with higher doses.



Steps before therapeutic opioid trial:

Opioids should only be part of a tailored treatment plan. Prior to starting, consider alternatives, and screen for risk of addiction, abuse or adverse outcome using tools like “Opioid Risk Tool” or “Screener & Opioid Assessment for Patients with Pain-Revised”. Obtain history of alcohol/substance abuse use. Opioids may not be helpful for conversion or somatization disorder, or pain from psychological factors (anxiety, depression, history of substance abuse). While patients may misuse opioids for these, there are better alternatives. Document the basis for any clinical decision to withhold opioids on inconsistencies in history, presentation, behaviors, or physical findings for patients requesting them.

- Determine if pain is nociceptive or neuropathic (neuropathic may require higher dose, though opioids would not be first-line therapy) and if there are underlying psychological issues.
- A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.
- Doctor and patient should set goals; continued use of opioids should be contingent on meeting those goals.
- Baseline pain and functional assessments should be made to include social, physical, psychological, daily/work activities, history of pain treatment, and effect of pain and function.
- Assess likelihood patient could be weaned from opioids if there is no improvement in pain and function.
- Conduct physical and psychological assessment; if subjective complaints don’t correlate w/imaging or physical findings or if psychosocial concerns exist, obtain specialist opinion.
- Discuss risks and benefits with the patient or caregiver.
- Use written consent or pain agreement to document patient education, treatment plan, and informed consent.
- Conduct urine drug screen for opioid misuse, illegal drug use.
- Check State Prescription Monitoring Program for duplicate prescribers or inconsistent prescription fills.

When to continue opioids:

- If the patient has returned to work.
- If the patient has improved functioning and pain.

When to discontinue opioids:

Determine if treatment failure is due to correctable causes such as under-dosing or an inappropriate schedule. If not, weaning should occur under direct medical supervision as slow taper.

- Continuing pain with intolerable adverse effects.
- Lack of significant benefit (persistent pain or no improved function despite doses of opiates up to 120 mg/day MED).
- Resolution of pain, or patient requests discontinuing.
- If serious non-adherence is occurring.
- Evidence of illegal activity (diversion, forgery, or stealing).
- Car accident or arrest related to opioids, alcohol, or illicit drugs; suicide attempt; aggressive or threatening behavior.
- Repeat violations from opioid contract or evidence of abuse/addiction. Consider referral to addiction specialist.

ODG Opioid Drug Formulary: First-Line: (Yes or No)

Brand Name	Generic Name	Status
Abstral	Fentanyl transmucosal	N
Actiq®	Fentanyl lollipop	N
Avinza®	Morphine ER	N
Buprenex®	Buprenorphine (injection for detox)	Y
Butrans™	Buprenorphine(transdermal)	N
Codeine	Codeine	Y
Combunox	Oxycodone/ibuprofen	N
ConZip	Tramadol ER	N
Darvocet®	Propoxyphene/acetaminophen	N
Darvon®	Propoxyphene hcl	N
Darvon-N®	Propoxyphene napsylate	N
Demerol®	Meperidine	N
Dilaudid®	Hydromorphone	Y
Duragesic®	Fentanyl transdermal	Y
Embeda	Morphine ER / Naltrexone	Y
Exalgo	Hydromorphone ER	N
Fentora®	Fentanyl buccal	N
Fioricet®	Butalbital (a barbiturate)	N
Kadian®	Morphine ER	N
Lazanda	Fentanyl nasal spray	N
Levo-Dromoran®	Levorphanol	Y
Lortab®	Hydrocodone/acetamin.	Y
Methadose®	Methadone (link to rules)	N
Morphine	Morphine	Y
Morphine	Morphine ER	Y
Nucynta™	Tapentadol	N
Onsolis™	Fentanyl buccal film	N
Opana®	Oxymorphone	N
Oxecta	Oxycodone	N
OxyContin®	Oxycodone ER	N
OxyIR®	Oxycodone	Y
Percocet®	Oxycodone/acetaminophen	Y
Percodan®	Oxycodone/aspirin	N
Prialt®	Ziconotide (morphine pump)	N
Suboxone®	Buprenorphine (for pain)	N
Suboxone®	Buprenorphine/Naloxone (detox)	Y
Subsys®	Fentanyl sublingual spray	N
Subutex®	Buprenorphine (for detox)	Y
Talwin	Pentazocine lactate	N
Talwin NX	Pentazocine/Naloxone	N
Tylenol #3	Codeine/acetaminophen	Y
Ultracet®	Tramadol/Acetaminophen	Y
Ultram ER®	Tramadol ER	Y
Ultram®	Tramadol	Y
Vicodin®	Hydrocodone/acetaminophen	Y
Vicoprofen®	Hydrocodone/ibuprofen	N

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