Combatting the Opioid Epidemic

In 2017:

2,217

Number of doses of naloxone administered by emergency medical services (EMS), law enforcement, or the Community Opioid Overdose prevention program in counties covered by CDPHP®

165,000

Number of opioid prescriptions written for CDPHP members (almost 10.5 million units)

183

Number of CDPHP members who had a documented heroin overdose

283

Number of members who had a documented opioid overdose (prescription opioids and heroin)

20%

Percentage of members who continued to receive opioids after the overdose

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CDPHP®

A plan for life.

New York State – County Opioid Quarterly Report. Available at: **www.health.ny.gov/statistics/opioid/data/pdf/nys_jul18.pdf**. *Published July 2018*

Before prescribing an opioid, consider these guidelines:

Treating Acute Pain

- Educate the patient about expectations for healing and the duration and intensity of pain. Acute pain duration necessitating opioid use is typically ‹ three to seven days.
- Advise appropriate behavioral modifications (initial rest, graded exercise).
- Provide external pain-reducing modalities (immobilization, heat/cold, and elevation).
- Advise of appropriate OTC medications.
- If considering opioids, assess the risk for misuse (previous addiction history, overdose, suicidality).
- Use the lowest possible dose for the shortest amount of time.
- **Legislation enacted in 2016 mandates that no more than a seven-day supply of an opioid may be prescribed upon the initial consultation or treatment for acute pain.**
- Do not prescribe additional opioids without having the patient return for an evaluation.
- Review the prescription monitoring program (PMP).
- Prescribe additional opioids if clinically appropriate. Otherwise, reinforce non-opioid modalities for pain control.

Treating Chronic Pain

Opioids are not first-line therapy for chronic pain. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred.

- Before starting opioid therapy for chronic pain:
  - Assess the risk for opioid overdose (history of overdose, substance use disorder, high opioid dosages, or concurrent benzodiazepine use).
  - Establish realistic treatment goals for pain levels and functionality.
  - Discuss how therapy will be discontinued.
  - Assess known risks.
- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
- Prescribe the lowest effective dosage. Avoid increasing the dosage to ›90 morphine milligram equivalents, or carefully justify the decision.
- Evaluate the benefits and harms with the patient within one to four weeks and every three months.
- Review the prescription monitoring program.
- Avoid prescribing opioid pain medication and benzodiazepines concurrently.
- Offer medication-assisted treatment for patients with opioid use disorder.

Opioids and Benzodiazepines

In August 2016, the Food and Drug Administration (FDA) announced that they would require manufacturers to include a black box warning to highlight the dangers of prescribing concurrent opioids and benzodiazepines:

> "Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate; limit dosages and durations to the minimum required; and follow patients for signs and symptoms of respiratory depression and sedation."

CDC Guideline for Prescribing Opioid for Chronic Pain – United States 2016; Responsible, Safe, and Effective Prescription of Opioid for Chronic Non-Cancer Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines; VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain; U.S. Food & Drug Administration (FDA)

When to Taper

Consider tapering to reduce the dosage or to discontinue opioid therapy when:

- It's clinically appropriate based on pain level.
- There is not a clinically meaningful improvement in pain and function.
- Dosage is exceeding 90 morphine equivalents daily without benefit.
- Opioids are combined with benzodiazepines.
- There are signs of substance use disorder.
- Overdose or risk factors for overdose are present.

How to Taper

Basic principles: Tapering plans should be individualized and should minimize withdrawal symptoms while maximizing pain treatment with non-pharmacologic therapies and non-opioid medications. For longer-acting drugs and a more stable patient, use a slower tapering plan. For shorter-acting drugs and a less stable patient, use a faster tapering plan.

A decrease of 10 percent of the original dose per week is a reasonable starting point. Assess the patient's functional and pain status at each visit. Make sure patients receive appropriate psychosocial support. Do not reverse the taper. The rate may be slowed or paused while monitoring for and managing withdrawal symptoms (see table for treatment of opioid withdrawal).

Restlessness, sweating, or tremors	Clonidine 0.1-0.2 mg orally every 6 hours; monitor for significant hypotension and anticholinergic side effects
Nausea	Anti-emetics, such as ondansetron or prochlorperazine
Diarrhea	Loperamide or anti-spasmodics, such as dicyclomine
Muscle pain, neuropathic pain, or myoclonus	NSAIDs, gabapentin, or muscle relaxants, such as cyclobenzaprine, tizanidine, or methocarbamol
Insomnia	Sedating antidepressants, such as nortriptyline 25 mg at bedtime, mirtazapine 15 mg at bedtime, trazodone 50 mg at bedtime

Resources

Please visit our website at **www.cdphp.com/safeopioids** for safe opioid prescribing tips, as well as links to continuing medical education (CME) programs, guidelines, and mentoring services. These resources are provided by the following organizations:

- The Centers for Disease Control and Prevention (CDC)
- Providers' Clinical Support System (PCSS)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Boston University
- The American Academy of Family Physicians
- The American Academy of Addiction Psychiatry (AAAP)
- The American Society of Addiction Medicine

For information on CDPHP network providers who treat opioid addiction, please call the CDPHP Behavioral Health Access Center at 1-888-320-9584.

Effective January 1, 2018, the Commercial and Medicaid formulary opioid medications are as follows:

Drug	Formulary Status (Commercial and Medicaid)
Acetaminophen/codeine tablets, *all strengths*	QL, 300 tablets/30 days
Acetaminophen/codeine solution 120-12/5 mL	QL 3,750 mL/30 days
Buprenorphine transdermal patch, *all strengths*	QL, 4 patches/30 days
Fentanyl citrate lozenges, *all strengths*	PA, QL, 4 doses/day
Fentanyl patch, *all strengths**	PA, QL, 10 patches/30 days
Hydrocodone/acetaminophen solution 7.5-325/15 mL	QL, 2,250 mL/30 days
Hydrocodone/acetaminophen tablets, *all strengths*	QL, 300 tablets/30 days
Hydrocodone-ibuprofen tablets 7.5-200	QL, 180 tablets/30 days
Hydromorphone liquid 1 mg/mL	QL, 180 mL/30 days
Hydromorphone tablets 2mg, 4 mg	QL, 180 tablets/30 days
Hydromorphone tablets 8 mg	QL, 120 tablets/30 days
Hydromorphone extended release tablets, *all strengths**	PA, QL, 60 tablets/30 days
Methadone tablets, *all strengths*	PA, QL 90 tablets/30 days
Morphine solution 10 mg/5 mL, 20 mg/5mL	QL 900 mL/30 days
Morphine suppositories, *all strengths*	QL, 120 suppositories/30 days
Morphine IR tablets 15 mg	QL, 180 tablets/30 days
Morphine IR tablets 30 mg	QL, 120 tablets/30 days
Morphine ER tablets 15 mg, 30 mg	PA, QL, 90 tablets/30 days
Morphine ER tablets 60 mg, 100 mg, 200 mg *	PA, QL, 60 tablets/30 days
Nucynta immediate release, *all strengths*	PA, QL, 180 tablets/30 days
Nucynta ER, *all strengths*	PA, QL, 60 tablets/30 days
Oxycodone/acetaminophen tablets 2.5-325, 5-325, 7.5-325	QL, 300 tablets/30 days
Oxycodone/acetaminophen tablets 10-325	QL, 240 tablets/30 days
Oxycodone/aspirin tablets 4.8355-325	QL, 308 tablets/30 days
Oxycodone/ibuprofen tablets 5-400	QL, 270 tablets/30 days
Oxycodone solution 5mg/5mL	QL, 900 mL/30 days
Oxycodone capsule 5 mg	QL, 240 tablets/30 days
Oxycodone IR tablet 5 mg, 10 mg	QL, 240 tablets/30 days
Oxycodone IR tablet, 15 mg, 20 mg	QL, 120 tablets/30 days
Oxycodone IR tablet 30 mg	QL, 60 tablets/30 days
Oxycodone ER tablets, *all strengths**	PA, QL, 90 tablets/30 days
Oxymorphone IR tablets, *all strengths*	PA, QL, 120 tablets/30 days
Oxymorphone ER tablets, *all strengths**	PA, QL, 60 tablets/30 days
Tramadol/acetaminophen tablets 37.5-325	QL, 240 tablets/30 days
Tramadol tablets 50 mg	QL, 240 tablets/30 days
Tramadol ER tablets, *all strengths*	QL, 30 tablets/30 days

** Requests for medication exceeding a 120 mg morphine milligram equivalent (daily dose) will require that additional prior authorization criteria is met.*