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Learning Objectives

- Practice safe and competent opioid prescribing for acute pain
- Prescribe opioids using universal precautions while individualizing care based on level of risk
- Educate patients and families about the safe use of and risks associated with opioid analgesics
- Communicate to patients and/or family members how to properly store and dispose of unused medications

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Reasons for the Course

- Use of all prescription opioids has dramatically increased.
- Opioid use disorder, overdose, and death associated with misuse of prescription opioids have also dramatically increased.
- In 2009, dentists prescribed 8% (6.4 million prescriptions) of opioid analgesics used in the United States.*
- Clinicians have the difficult task of balancing the relief of pain with the need to prevent adverse outcomes for their patients, families, and community.

*Volkow et al., 2011

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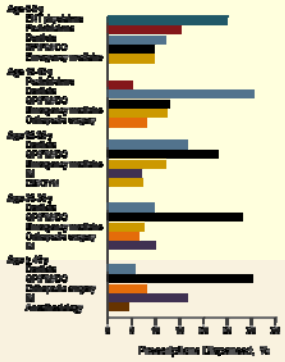
Reasons for the Course (continued)

Percentage of Prescriptions Dispensed for Opioid Analgesic From Outpatient US Retail Pharmacies by Age and Physician



Volkow et al., 2011

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Purpose of the Training

This training COVERS the safe and competent use of opioids for managing acute moderate to severe dental pain.

This training DOES NOT COVER an extensive review of:

- Nonopioid management of acute pain
- Management of chronic pain

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Case Study: Melanie Stokes

- New patient
- 31 years old
- Past medical history is not contributory
- No routine dental care for more than 3 years
- Ms. Stokes reports to the dental assistant that she is in severe pain and needs a prescription for Vicodin

CLINICIAN QUESTION:

Should you be concerned about her request for opioids and her specific request for "Vicodin?"

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Acute Pain Is Complex

- "…the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus . . . associated with surgery, trauma and acute illness."
- Attitudes, beliefs, and personalities also strongly affect the immediate experience of acute pain.
- Not all patients experience pain in the same way.
- Factors that increase the painful experience include:
  - Anxiety, depression
  - Sleep disruption
  - Substance use disorder (SUD)

Carr & Goudas, 1999

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Opioids: The Benefits of Treating Acute Pain

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Opioid Pharmacodynamics

- Turn on descending inhibitory systems in the midbrain
- Prevent ascending transmission of pain signal
- Inhibit terminals of C-fibers in the spinal cord
- Inhibit activation of peripheral nociceptors
- **However**, opioids also activate opioid receptors in the midbrain ("reward pathway"), resulting in reward and euphoria.

McCleane & Smith, 2007

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Patients Requesting a Specific Opioid by Name

Although requests for specific opioids may be concerning for opioid misuse (e.g., diversion), they may also represent innocent reports on which opioid the patients have tolerated and found beneficial in the past.

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Variable Response to Opioids

- All patients who receive opioid medications for pain have different responses to specific opioids and doses.
- Mu-opioid receptor differences
  - >100 polymorphisms in the human MOR gene
  - Mu-opioid receptor subtypes
- Opioid pharmacokinetics differences
  - Opioid metabolism differs by individual opioid and by individual patient
  - For example, patients with impaired CYP2D6 metabolism do not respond to codeine

Smith, 2008

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Prescription Opioids

Immediate Release/ Short-Acting (IR/SA)

- Morphine
- Hydrocodone
- Hydromorphone
- Oxycodone
- Oxymorphone
- Tramadol
- Tapentadol
- Codeine

Extended Release/ Long-Acting (ER/LA)

- Morphine
- Hydrocodone
- Hydromorphone
- Oxycodone
- Oxymorphone
- Tramadol
- Tapentadol
- Methadone
- Fentanyl transdermal
- Buprenorphine transdermal

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Prescription Opioids (continued)

- Due to slow onset of action and high-dose formulations, ER/LA opioids should not be prescribed for acute pain in opioid-naïve patients.
- A patient who is already taking ER/LA opioids for chronic pain should obtain refills from the provider who is managing his/her chronic pain.

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Comparative Efficacy of Medications for Acute Pain

- Most cases of postoperative dental pain include an inflammatory component.
- Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) are therefore rational first-line agents, and they often are more effective than conventional dosages of opioids.
- Mild to moderate pain generally can be managed by using optimal doses of nonopioids: ibuprofen 400–800 mg, acetaminophen 1,000 mg, or a combination of the two.

McQuay et al., 2012

15

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Comparative Numbers Needed to Treat (NNT)

Acute Dental Pain: NNT for at least 50% maximum pain relief over 4–6 hours compared with placebo, by rank order

Medication	Studies	Participants	NNT (95% CI)
Ibuprofen/Acetaminophen 200/500 mg	2	280	1.6 (1.4–1.6)
Naproxen 500/550 mg	5	402	1.8 (1.6–2.1)
Codeine/Acetaminophen 60/1,000 mg	26	2,295	2.2 (1.8–2.9)
Oxycodone/Acetaminophen 10/650 mg	6	673	2.3 (2.0–2.6)
Ibuprofen 400 mg	49	5,428	2.3 (2.2–2.4)
Celecoxib 400 mg	4	620	2.5 (2.2–2.9)
Tramadol/Acetaminophen 75/650 mg	5	659	2.9 (2.5–3.5)
Acetaminophen 600/650 mg	10	1,276	4.2 (3.6–5.2)
Aspirin 600/650 mg	45	3,581	4.5 (4.0–5.2)
Tramadol 100 mg	7	578	4.6 (3.6–6.4)
Codeine 60 mg	15	1,146	21.0 (12.0–96.0)

Moore et al., 2011

16

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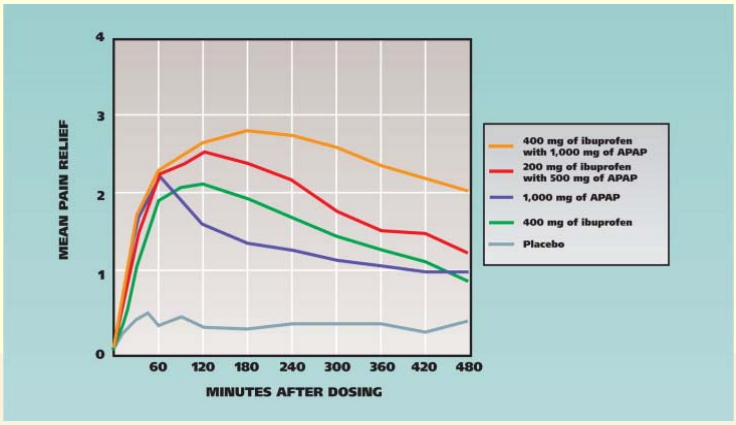
Rational Polypharmacy



Moore & Hersh, 2013

17

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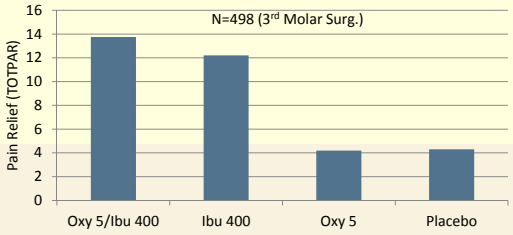
Rational Polypharmacy (continued)

- Combine analgesics from different medication classes (e.g., NSAIDs, acetaminophen, opioids) for synergy
- A study of 498 patients with third molar impaction surgery found the following:



Van Dyke et al., 2004; Graph modified from *Becker, 2010*

18

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Efficacy of Analgesic Combinations

Efficacy of Analgesic Combinations for Post-Operative Pain after 3rd Molar Surgery

Systematic Review and Meta-Analysis of Randomized Clinical Trials

Drug Combination	Studies (subjects)	SPID6* *Adjusted*	TOTPAR6** *Adjusted*
Ibuprofen 400 mg + oxycodone 5 mg	2 (248)	6.44	9.31
Acetaminophen 325 mg + oxycodone 5 mg	1 (62)	2.89	4.48
Acetaminophen 500 mg + hydrocodone 7.5 mg	2 (156)	2.89	4.51
Acetaminophen 300 mg + codeine 30 mg	3 (255)	1.46	3.24
Acetaminophen 500 mg + ibuprofen 200 mg	1 (173)	1.16	1.92

SPID6:** Sum of Pain Intensity Difference in 6 hours (pain intensity score at baseline [after local anesthetic effect subsided] minus the pain intensity scores hourly for 6 hours). **The higher score represents more effective analgesia.

****TOTPAR6:** Total Pain Relief in 6 hours. The summation of pain relief score (0=none to 4=complete) on each hour in the first 6 hours. For example: complete pain relief for 6 hours (6 hours x 4 = 24). **The higher score represents more effective analgesia.***

Au et al., 2015

19

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Recommended Prescribing Practices for Acute Pain

- Individualize treatment based on severity of pain and medical history
- Maximize nonopioids before adding an opioid
- Monitor for potential NSAID-related renal, GI, and cardiac adverse effects and acetaminophen-related liver adverse effects when prescribing high doses and for extended lengths of time
- Consider:
  - Preoperative dose
  - Loading dose
  - Prescribing around-the-clock instead of prn on first day
- Reduce the dose and duration of any NSAID or opioid in the elderly

Becker, 2010; Haas, 2002; Fletcher, 2012

20

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Opioids: The Risks

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Use of Opioids to Treat Acute Dental Pain

- Care needs to be used when prescribing opioids for dental pain.
  - Check the prescription drug monitoring program (PDMP) before writing a prescription for an opioid
- Screen patients for prescription opioid misuse risk such as current or history of substance use disorders (SUDs)
  - Develop a referral network for the treatment of SUDs
- Minimize risk of diversion by educating patients about:
  - How to store opioids safely (e.g., locked box)
  - Proper disposal of unused opioid medications

Volkow et al., 2011; Denisco et al., 2011

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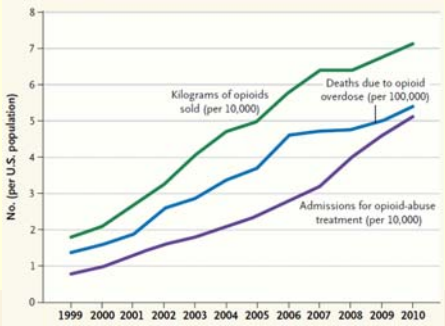
Opioid Sales, Deaths, and SUD Treatment Admissions

Rates* of opioid pain reliever (OPR) overdose death, OPR treatment admissions, and kilograms of OPR sold in the United States, 1999–2010



* Age-adjusted rates per 100,000 population for OPR deaths, crude rates per 10,000 population for OPR abuse treatment admissions, and crude rates per 10,000 population for kilograms of OPR sold.

Centers for Disease Control and Prevention (CDC), 2011

23

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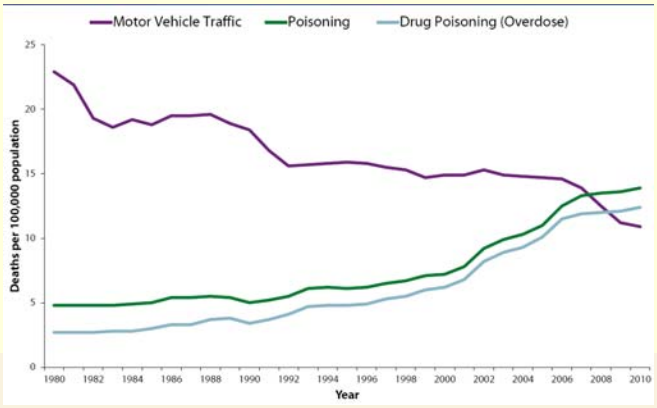
Drug Overdose Death Rates (1980–2010)



Warner et al., 2011

24

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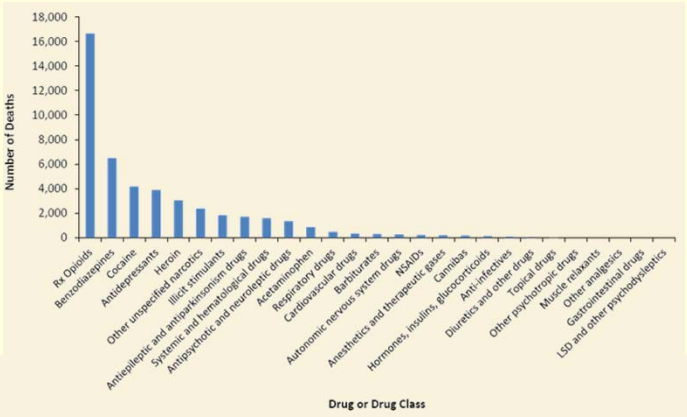
Prescription Drugs: Primary Driver of Overdose Deaths, U.S. 2010



CDC, 2012

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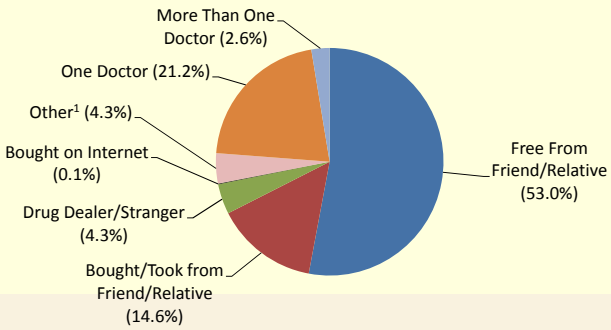
Where Pain Relievers Were Obtained

Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use Among Past-Year Users Aged 12 or Older: 2012–2013



1 The Other category includes the sources "Wrote Fake Prescription," "Stole from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."
Note: The percentages do not add to 100 percent due to rounding.

Substance Abuse and Mental Health Services Administration (SAMHSA), 2014

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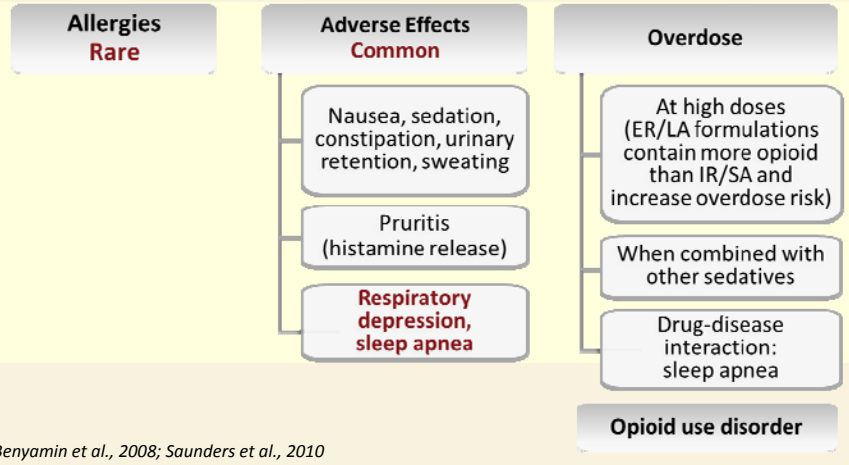
Opioid Safety and Risks



Benyamin et al., 2008; Saunders et al., 2010

27

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Respiratory Depression

- Depression of the medullary respiratory center
- Decreased tidal volume and minute ventilation
- Right-shifted CO_2 response
- Hypercapnea, hypoxia, and decreased oxygen saturation
- Immediately life threatening
- Sedation occurs before significant respiratory depression and therefore is a warning sign

Because of the possibility of respiratory depression, patients should be counseled not to increase dose to get better pain control, especially at night when respiration rate normally decreases.

Dahan et al., 2010

28

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Specific Opioid Risks in the Elderly

- Drug–drug interactions
- Drug–disease interactions:
  - CHF, COPD, sleep apnea, chronic liver and renal disease
  - Dementia
  - Decline in therapeutic index
  - Age-related predisposition to adverse drug effects
- Fall risk

American Geriatrics Society Panel, 2009; Fine, 2012

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Case Study: Checking the PDMP

- Dr. Gunderson reviews the PDMP before entering the exam room.
- PDMP: The patient has received 2 prescriptions for hydrocodone 5 mg/acetaminophen 300 mg (10 tablets each) from 2 different doctors in the past 2 weeks.
- Dr. Gunderson notes the date each prescription was filled.

CLINICIAN QUESTION:

How should you use this PDMP information when responding to the patient's request for opioids?

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PDMPs

- Statewide electronic databases on dispensed controlled substance prescriptions
- Prescription data available for the past year, including information on date dispensed, patient, prescriber, pharmacy, medicine, and dose
- Many states mandate use before writing prescriptions for controlled substances
- Several studies* suggest association between PDMP use and positive outcomes related to improving prescribing and reducing prescription drug abuse
- Discuss PDMP information with the patient openly and nonjudgmentally…"I see that you have received multiple opioid prescriptions from multiple providers filled at multiple pharmacies…can you tell me about this?"

*http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf

Haffajee et al., 2015

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Case Study: Visit 1

Ms. Stokes explains that she:

- Developed severe right-sided tooth pain 2 weeks ago
- Went to two different emergency departments; each time she was prescribed a small number of Vicodin pills (shown in the PDMP) and was instructed to follow up with a dentist
- Chose Dr. Gunderson on recommendation of a friend
- Is having a difficult time caring for two young children because of severe pain

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Case Study: Visit 1 (continued)

- On exam, Dr. Gunderson sees a large cavity in #30 (first molar, right side), extending to pulp.
  - #30 is tender to percussion
  - Mild swelling in lateral cheek vestibule, which is tender to palpation
  - Mild periodontal disease and temperature of 100°F
  - Radiographic evidence of periapical pathology but restorable tooth with endodontic therapy, post/core and crown
- He recommends a root canal and crown.

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Case Study: Visit 1 (continued)

- Ms. Stokes does not have insurance to cover the costs.
- Dr. Gunderson recommends extraction.
- Ms. Stokes says she cannot have the extraction done today and that the Vicodin she got from the emergency room doctors worked pretty well on the pain but she ran out.
- She asks for more Vicodin to tide her over until the scheduled extraction.

CLINICIAN QUESTION:

How would you assess her risk for prescription opioid misuse?

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Implement Universal Precautions in Pain Medicine

Part of an Office Controlled Substance Policy

- Predicting prescription opioid risk and misuse is imprecise
  - Protects all patients
  - Protects the public and community health
- Consistent application of opioid prescribing precautions:
  - Reduces stigmatization of individual patients
  - Standardizes system of care
- Resonant with expert guidelines from:
  - American Pain Society/American Academy of Pain Medicine
  - American Society of Interventional Pain Physicians
  - American Academy of Neurology
  - Federation of State Medical Boards
  - Canadian National Pain Centre

Gourlay et al., 2005; Nuckols et al., 2014

35

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Universal Opioid Prescribing Precautions for Dentists

Prior to prescribing, perform the following universally for ALL patients prescribed opioids:

- Check state PDMP data to corroborate patient's history of opioid use
- Talk to all other providers (e.g., primary care), as appropriate
- Assess prescription opioid misuse risk, including substance use (tobacco, alcohol, illicit drugs, prescription drug misuse) history
- Prescribe minimum amount of opioids based on the expected duration of severe pain
- Give specific opioid prescribing directions (e.g., no more than four tablets in a day)
- If pain is more severe or lasts longer than expected, reassess patient before prescribing additional opioids
- Explain how to store opioids safely (e.g., a locked box/cabinet)
- Tell patients how to properly dispose of any unused opioids

36

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Prescription Opioid Misuse Risk Factors

- Personal history of substance use disorder (illicit, prescription, alcohol, nicotine)
- Young age (less than 45 years)
- Family history of SUD
- Legal history (DUI, incarceration)
- Mental health problems

Akbik et al., 2006; Ives et al., 2006; Liebschutz et al., 2010; Michna et al., 2004; Reid et al., 2002

37

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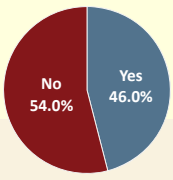
Screening for Unhealthy Alcohol Use

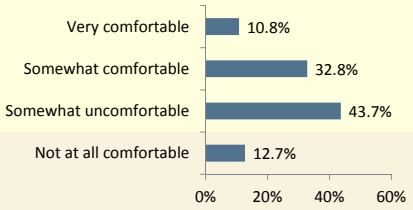
According to the most recent American Dental Association (ADA) survey (2007):

- More than half (54.0%) of dentists do not ask their patients about alcohol use.
- Of those who **do not** ask, more than half (56.4%) were either somewhat uncomfortable or not at all comfortable asking patients about their alcohol use.

Do you currently ask your patients about their alcohol use?



If no, how comfortable would you feel about asking?



ADA, 2008

38

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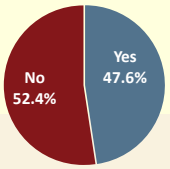
Screening for Drug Use

According to the most recent ADA (2007) survey:

- Over half (52.4%) of dentists do not ask their patients about their use of illegal substances.
- Of those who **do not** ask about illegal substance use, most dentists (65.6%) feel either somewhat uncomfortable or not at all comfortable about asking the question.

Do you currently ask your patients about their use of illegal substances?



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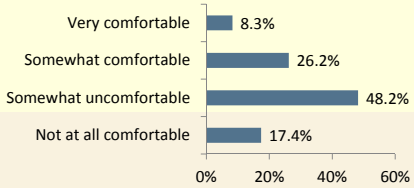

ADA, 2008

39

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Quick Screen for Unhealthy Tobacco, Alcohol, and Drug Use

Before prescribing any opioid for acute pain, patients should be screened for tobacco, alcohol, and other drug use.

- **Tobacco:** "Do you currently use tobacco?"
- **Alcohol:** "Do you sometimes drink beer, wine, or other alcoholic beverages?" "**How many times** in the past year have you had five (four for women) or more drinks in a day?" **(positive: > never)**
- **Drugs:** "**How many times** in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" **(positive: > never)**

Smith et al., 2009; Smith et al., 2010

40

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Interpreting Answers to the Screening Questions

*Substance use disorders

Image from SBIRT Clinician's Toolkit, www.MASBIRT.org/SBIRT-information

41

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Screener and Opioid Assessment for Patients with Pain—Short Form (SOAPP–SF)

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

- How often do you have mood swings?
- How often do you smoke a cigarette within an hour after you wake up?
- How often have you taken medication other than the way it was prescribed?
- How often have you used illegal drugs (e.g., marijuana, cocaine) in the past 5 years?

(≥4 is positive; <4 is negative)

SOAPP, 2008; Akbik, 2006

42

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Case Study: Visit 1 Screening

- Ms. Stokes screens positive for prescription opioid misuse risk on the SOAPP–SF. (Her score is 4 because she smokes "very often.")
- Substance use screen was negative for drug use and prescription opioid misuse but positive for tobacco use and unhealthy alcohol use (binge drinker).
- She does admit to heavy daily marijuana use in the distant past but denies use in over a decade.

CLINICIAN QUESTION:

How would you counsel Ms. Stokes about her prescription opioid misuse risk and unhealthy alcohol use?

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Brief Intervention Counseling for Unhealthy Substance Use

A brief intervention provides counseling for unhealthy substance use and increased prescription opioid misuse risk.

Feedback: Provide personalized feedback and state your concern.

- Concern about increased prescription opioid misuse due to her smoking history
- Health risk including binge drinking and increasing risk of accident and trauma
- Overdose risk of combining alcohol with opioid pain medications

Bien, 1993

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Brief Intervention Counseling for Unhealthy Substance Use (continued)

Advice: Make a nonjudgmental yet explicit recommendation for change in behavior.

- Cut down to lower-risk amounts to protect health
- No drinking while taking opioid medications to avoid oversedation

Goal setting: Discuss patient's reaction and discuss plan for behavior change

- "What do you think about these recommendations?"
- "Are you ready and able to make this change?"
- "How will you make this change?"

Bien, 1993

45

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Managing Acute Pain in Patients with History of SUD

- Frame SUD as a challenging health issue
- Express admiration for patient's recovery
- Acknowledge patient's desire to "never go there again"
- Explain that history of SUD is associated with increased pain sensitivity (pain intolerance)
- Reassure the patient that pain will be managed regardless of SUD history
- As with all patients, manage pain with nonopioids if appropriate
- Due to increased opioid misuse risk, increase structure of care (e.g., smaller supply of medication, closer follow-up)

Alford et al., 2006; Savage et al., 2008

46

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Managing Acute Pain in Patients with History of SUD on Medication-Assisted Treatment

- Patients on Opioid Agonist Therapy (OAT) (e.g., methadone, buprenorphine) can and should receive analgesia concurrently.
  - Continue OAT and provide aggressive pain management that combines effective communication, monitoring, and appropriate medications for treatment of pain.

Alford et al., 2006

47

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Managing Acute Pain in Patients with History of SUD on Medication-Assisted Treatment continued

- Opioid Antagonist Therapy (e.g., naltrexone PO, IM depot) will block the effects of a co-administered opioid analgesic.
  - If the surgery is elective, discontinue naltrexone.
    - PO naltrexone: 50% of blockade effect gone after 72 hours
    - IM depot naltrexone: If possible, delay elective surgery for a month after last dose
  - If the acute pain is current or the surgery is urgent or emergent, use nonopioids and aggressive nerve block therapy.

Vickers, 2006

48

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Case Study: Scheduling of Extraction

- Ms. Stokes is surprised that her drinking is considered risky and is willing to cut down.
- Dr. Gunderson schedules the extraction in 3 days.
  - He prescribes a limited supply of hydrocodone 5 mg/acetaminophen 300 mg 1 tablet po q6 prn pain (max 3 tablets per day) (#9 pills) and ibuprofen 600 mg tid (with meals).
  - He also prescribes penicillin 500 mg QID and perioguard
  - He educates Ms. Stokes about possible interaction between alcohol and prescription opioid medications; and collateral opioid risks and how to mitigate those risks.
  - He educates Ms. Stokes about safe storage of opioid medication and the risk of pediatric exposure.
- Ms. Stokes agrees to not drink when she is taking prescribed medications and will store opioids out of reach of her children.

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Collateral Opioid Risks

- Risks
  - Young children's ingestion and overdose
  - Adolescent experimentation leading to overdose and an opioid use disorder
- Mitigating risk
  - Safe storage (e.g., lock box)
  - Educate family members about risk
  - Have poison control number handy
  - Naloxone distribution (if available)*
  - Proper disposal

**SAMHSA Opioid Overdose Prevention Toolkit, 2014*

Beletsky et al., 2012

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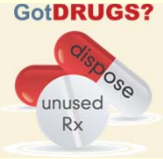
Opioid Disposal

Tell patients to dispose of any unused opioids by providing information about:

- Local take-back program, if available
- Drug Enforcement Agency (DEA)-authorized collection sites (e.g., pharmacies, hospitals, law enforcement locations)
- Disposal in household trash (mix uncrushed pills with kitty litter or coffee grounds, seal in plastic bag, and put in trash)
- Flush down the toilet if appropriate; consult the 2015 FDA list at www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/UCM337803.pdf



51

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Case Study: Phone Call

- Ms. Stokes calls to cancel her appointment because her son is sick with a fever and needed to stay home from school.
- She says her tooth pain is killing her and that the Vicodin helped but she has run out.
- She is requesting a Vicodin refill over the phone.

CLINICIAN QUESTION:

How would you address her request for an opioid refill over the phone?

52

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Is refilling an opioid prescription without seeing the patient legal?

CFR 1306.04(a)

"A prescription for a controlled substance must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice."

"The responsibility for the proper prescribing and dispensing of controlled substances rests on the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription."

Title 21 Code of Federal Regulations Part 1306, 1306.04

53

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Federal and State Laws and Regulations—A Common Theme

- A valid provider–patient relationship must exist.
- The prescription must be issued for a valid medical purpose.
- The prescription must be therapeutic for the patient's condition.
- The provider and pharmacist have a corresponding responsibility to determine the prescription is valid.

54

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Refilling an Opioid Prescription

Is refilling an opioid prescription without seeing the patient good clinical practice?

- Not for a new patient who you are not certain can take opioids safely
- Not if the patient has been nonadherent with treatment instructions in the past
- Not if the patient's pain is persisting longer than anticipated

55

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Controlled Substance Act: Opioid Schedules

Schedule II

- High abuse potential and severe dependence liability
- Examples:
  - Morphine
  - Codeine
  - Hydromorphone
  - Oxycodone
  - Hydrocodone (moved to Schedule II in 2014)

Schedule III

- Moderate dependence liability
- Example:
  - Tylenol with codeine (Tylenol #3)

56

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Schedule II Controlled Substance Rules

- These require a prescription that must be signed by the practitioner.
- There is no federal time limit within which a Schedule II prescription must be filled after being signed by the practitioner.
- Some states and many insurance carriers limit the quantity of controlled substance dispensed to a 30-day supply; there are no specific federal limits to quantities of drugs dispensed via a prescription.
- An oral order is only permitted in an emergency situation.

U.S. Department of Justice, 2006

57

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Schedule III Controlled Substance Rules

- A prescription may be communicated either orally, in writing, or by facsimile to the pharmacist and may be refilled if so authorized on the prescription or by call-in.
- The prescription may only be refilled up to 5 times within 6 months after the date on which the prescription was issued.

U.S. Department of Justice, 2006

58

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Case Study: Phone Call (continued)

- Dr. Gunderson explains nonjudgmentally and empathically that he does not feel comfortable prescribing additional opioids over the phone and recommends that Ms. Stokes continue taking acetaminophen and ibuprofen for pain until she can reschedule her extraction.
- He explains that her pain is not going to be properly treated without an extraction.
- The extraction is rescheduled for the following day.

59

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Case Study: Visit 2—Extraction

- An uncomplicated extraction of tooth #30 is performed.
- Dr. Gunderson prescribes ibuprofen 600 mg every 8 hours and hydrocodone 5 mg/acetaminophen 300 mg 1 tab every 6 hr for pain (max 4 tab/day); total of 8 tabs are prescribed.
- Ms. Stokes becomes angry and complains that 8 tablets are not enough to treat her pain and that she is very sensitive and she needs more.
- She says she will not be able to take care of her children if she is in severe pain
- Dr. Gunderson explains
  - The usual duration of post-op (extraction) pain is a couple of days and she will need to return for examination if the pain persists beyond that
  - Ibuprofen and acetaminophen are as effective for acute dental pain as opioids
  - The best pain control is with combination therapy

60

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Case Study: Phone Call 2 Days Later

- Ms. Stokes calls and is crying.
- She says that she was beginning to feel better and then last night was awakened with excruciating pain that now is causing ear and jaw pain on the right side.
- She has a foul odor and taste in her mouth.
- She denies fever or chills and says this pain is worse than the original pain.
- She doesn't think she can come to the office and wants Dr. Gunderson to call in prescriptions for more Vicodin.

CLINICIAN QUESTION:

- How would you interpret Ms. Stokes request for additional opioids? Is she "drug seeking" or "pain-relief seeking"?

61

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Concerning Behaviors: Differential Diagnosis

Pain-Relief Seeking

- Worsening pain due to infection, dry socket, etc.
- Exaggerated patient perception that opioids are the most effective treatment for acute dental pain, therefore if pain relief is inadequate more opioids are needed

Drug Seeking

- Opioid use disorder
- Medicating other psychiatric diagnosis (e.g., anxiety)
- Criminal intent (diversion)

Pain Relief and Drug Seeking

- For example, patient with acute pain, with co-morbid opioid use disorder, taking some medication for pain and diverting some for income

Alford, 2013

62

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Opioid Use Disorder (OUD) Criteria

- *Tolerance
- *Withdrawal
- Use in larger amounts or duration than intended
- Persistent desire to cut down
- Giving up interests to use opioids
- Great deal of time spent obtaining, using, or recovering from opioids

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

American Psychiatric Association, 2013

63

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Opioid Use Disorder (OUD) Criteria continued

- Craving or strong desire to use opioids
- Recurrent use resulting in failure to fulfill major role obligations
- Recurrent use in hazardous situations
- Continued use despite social or interpersonal problems caused or exacerbated by opioids
- Continued use despite physical or psychological problems

Mild OUD: 2–3 Criteria

Moderate OUD: 4–5 Criteria

Severe OUD: ≥6 Criteria

American Psychiatric Association, 2013

64

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Concerns About Prescription Opioid Misuse or Diversion

- What to do if you have concerns that a patient is misusing the prescription opioids
  - Check PDMP
  - Discuss your concerns openly with the patient, giving specific examples of observed behaviors making you concerned for risk or harm
- How to handle suspected diversion or opioid use disorder
  - Have the difficult conversation
  - Give specifics as to why you are concerned
  - For OUD, counsel the patient (brief intervention with feedback, advice, and goal setting) and refer to substance use treatment, if available

65

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Always Stay in Your Clinician Role

NOT

66

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Case Study: Urgent Visit, 2 Days After Extraction

- Dr. Gunderson says he needs to examine her and that prescribing more Vicodin over the phone without seeing her would not be appropriate.
- He can squeeze her in today for an urgent visit.
- Ms. Stokes arrives with her son and is in distress, crying and demanding pain medications.
  - Evidence of a dry socket without infection

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Case Study: Urgent Visit, 2 Days After Extraction (continued)

- Dr. Gunderson starts to irrigate the extraction site to remove food particles and necrotic material but patient is unable to tolerate the irrigation due to severe pain.
- Dr. Gunderson performs a nerve block, then irrigates and packs the socket with dry socket paste.
- Dr. Gunderson prescribes hydrocodone 5 mg/acetaminophen 300 mg 1 tab every 4–6 hours (no more than 4 tablets per day) #10 tablets with ibuprofen 800 mg every 8 hours.
- Ms. Stokes returns for daily follow-up assessment and treatment and her symptoms continue to improve.

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Case Study: Phone Call 1 Week Later

Ms. Stokes calls the office and says that while her pain is better she still has pain and needs more pain medication and requests a Vicodin refill. She is worried that without the Vicodin her pain will become so severe that she will not be able to care for her children.

Dr. Gunderson tells her that her pain will now be treated with nonopioids such as ibuprofen and acetaminophen and that if her pain gets worse she should call the office, as she will need to be reexamined.

Dr. Gunderson does not hear from Ms. Stokes again.

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Prescribing Opioids Using a Health-Oriented, Risk-Benefit Framework

NOT…

- Is the patient good or bad?
- Does the patient deserve opioids?
- Should this patient be punished or rewarded?
- Should I trust the patient?

RATHER…

- Are opioids indicated and safe for this patient? (In this case there was no further indication.)

Judge the opioid treatment, NOT the patient

Nicolaidis, 2011

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Staying in the Risk-Benefit Framework

- Use clinical judgment to determine indication and safety of opioid prescribing
- Understand the complexities of pain
- Identify pain-relief seeking vs. drug seeking vs. combination

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Summary

- Use universal precautions but individualize pain management based on risk
- Recognize that opioids have limited efficacy when used alone
- Combine medications for synergistic effect
- Prescribe opioids in limited amounts with clear directions
- Prior to prescribing opioids, assess patients for opioid misuse risk
- Educate patients about safe storage and disposal
- Use risk-benefit framework to guide clinical judgment

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