GUIDELINES

FOR THE EVALUATION AND TREATMENT OF CHRONIC PAIN BY PRIMARY CARE

(Not applicable for cancer, hospice, or palliative care)

Trillium Community Health Plan

New Patient:

Established Patient: **Reassess and minimize, taper, or stop opioid treatment**

(Periodically: Consider taper attempt for all patients)

ASSESSMENT

BEGIN

- Review medical history records from previous providers and Oregon PDMP
- Do physical exam, determine baseline function and pain
- Review prior treatments, including all non-opioid modalities
- Assess psychiatric comorbidity and history (PHQ 2, 9; GAD 7, etc.)
- Assess medication abuse and psychosocial risk (ORT, SOAPP, COMM, etc.)

NON-OPIOID OPTIONS

GREEN LIGHT

- Create a plan of treatment with the patient that incorporates non-opioid interventions
- Patient lifestyle improvement: Exercise, weight loss
- Behavioral therapies: CBT, peer support, case management, psychotherapy
- Physiotherapy modalities: OT, PT, passive modalities
- Medical interventions: Pharmacological, procedural, surgical
- Treat psychiatric comorbidity

OPIOID TREATMENT

CAUTION

Confirm diagnosis; check, is opioid treatment indicated?

- **Often useful:** Cancer, perioperative, burns, sickle cell, visceral eg. appendicitis, pancreatitis, kidney stone, etc. pain.
- **May be useful if non-opioid treatments not working:** Fractures; RA/rheumatologic; disabling acute back pain; peripheral neuropathy; short term use for flares of chronic pain; phantom limb; and HIV pain.
- **Not recommended and/or contraindicated :** Chronic nonspecific low back/degenerative disc disease; central neuropathic; pelvic; headache/orofacial; fibromyalgia; irritable bowel syndrome; somatization; substance use disorder; gastroparesis; myofascial pain.

Assessment and Preparation

- Assess sleep (S.T.O.P., B.A.N.G., Epworth Sleepiness Scale, etc.)
- Perform UDS prior to prescribing
- Use morphine equivalency dose calculator; start low, go slow; usually ≤ 30 med/day is enough
- Use Material Risk Notice and Treatment Agreement
- Agree on and document functional treatment goals
- It is seldom appropriate to prescribe chronic opioids on the first visit

Prescribing and Follow-up

- Avoid weekly refills; write 28 day scripts (or 7 day increments)
- Refill at appointment, not by phone
- Write pharmacy name and date-to-fill on script
- Recheck Q 4-12 weeks (Q 1-2 if needed) based on risks/dose changes
- Assess function, pain, aberrant behaviors, side effects at each visit
- Evaluate progress on treatment goals at each visit
- UDS ≥ annually and PDMP at each visit

REASSESS – CHANGE - STOP

STOP!

Re-evaluate your treatment plan and/or seek help from specialists if you:

- Are unsure of diagnosis or have any concerns
- Prescribe more than 90 mg MED/day without obvious functional improvement
- Prescribe opioids with benzodiazepines
- Prescribe more than 40 mg of methadone/day and are not specifically trained/experienced with this
- Notice signs of significant misuse or illicit drug use
- If not effective, you may try a different opioid: Reduce MED by 30% with change, taper back up if needed
- Top dose of opioids is lower if also using benzos (eg. 60 MED); however, no data supports a safe dose.

http://www.ohsu.edu/gim/epiclinks/opioidresources/opioidguidelines.htm

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TAPERING FLOWCHART

Trillium Community Health Plan

START HERE

Taper for opioid MED > 90 or methadone > 40, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function; impairment ; benzodiazepines with concurrent opioid use.
(No taper needed if UDS shows patient not taking drug). *Periodically consider taper attempt for all patients.*

1 – Explain to the patient the reason for the taper: "I'm concerned about your safety".
2 – If multiple drugs involved, taper one at a time (start with opioids, follow with benzos).
3 – Set a date to begin, provide information to the patient, and set up behavioral supports, prior to instituting the taper.
4 – Patients with chronic pain and co-morbid psychiatric disorders, such as panic disorder, may need to remain on benzos.

OPIOID TAPER

1. Utilize the drug the patient is taking as the tapering medication. If you switch medications, follow MED equivalency chart and then reduce the dose by 25 – 50% as starting dose. Metabolic variability can be quite significant. Utilize a 90 % dose reduction if switching to methadone.
2. Decrease total daily dose by 5 – 15% each week.
3. See patient frequently and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
4. After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the process down.
5. Consider adjuvant medications: Antidepressants, NSAIDS, clonidine, anti-nausea, anti-diarrhea agents.

Opioids (not methadone) – Basic Principle

Determine rate of taper based on risk. For longer acting drugs and a more stable patient, use slower taper. For shorter acting drugs, less stable patient, use faster taper.

Methadone – Basic principle

Very long half-life may necessitate a more protracted taper; otherwise, follow opioid principles.

BENZODIAZEPINE TAPER

1. Calculate total daily dose. Switch from short acting agent (alprazolam, lorazepam) to longer acting agent (diazepam, clonazepam). Upon initiation of taper reduce the calculated dose by 25 – 50% to adjust for possible metabolic variance.
2. First follow up visit 2 – 4 days after initiating taper to determine need to adjust initial dose.
3. Reduce the total daily dose by 5 – 10 % per week in divided doses.
4. After ¼ to ½ of the dose has been reached, with cooperative patient, you can slow the taper.
5. Consider adjunctive agents to help with symptoms: Trazodone, buspirone, hydroxyzine, clonidine, antidepressants, neuroleptics, and alpha blocking agents.

Basic Principle

Expect anxiety, insomnia, and resistance. Patient education and support very important. Risk of seizures with abrupt withdrawal increases with higher doses. The slower the taper, the better tolerated.

MED FOR SELECTED OPIOIDS

OPIOID	Approximate Equianalgesic Dose (oral and transdermal)
Morphine (reference)	30 mg
Codeine	200 mg
Fentanyl transdermal	12.5 mcg/hr
Hydrocodone	30 mg
Hydromorphone	7.5 mg
Methadone *non-linear pharmacokinetics*	**Chronic: 4 mg**
Oxycodone	20 mg
Oxymorphone	10 mg

BENZO EQUIVALENCY CHART

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

Link to Morphine Equivalent Dosing (MED) Calculator: https://www.easycalculation.com/medical/opioid-conversion-calculator.php

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