



# Risk Mitigation Strategies: Part 1

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# Disclosure/Conflict of Interest

I, Kenny Jackson, have no actual or potential conflict of interest in relation to this program.



# Learning Objectives – Part 1

- Identify common risk mitigation strategies including but not limited to use of PDMP, abuse risk screening tools, urine drug screening, patient informed consent, opioid agreements, pill counts, appropriate controlled substance storage and disposal, and communication
- Discuss benefits and challenges to each strategy
- Differentiate appropriate use of each strategy



# What is this?

- HG is a 39 yr old Caucasian female with intermittent back pain.
  - Never diagnosed, never prescribed opioids.
- She is routinely “chewing” controlled release oxycodone that is prescribed for her mother, although her mother is unaware of this.
- HG is always calling the physician & pharmacy to pick up the Rx early for her mother.



# What is this?

- DP is a 52 yr old Hispanic female with chronic headaches.
- She has been prescribed hydrocodone/APAP 5/500 mg & has been using 4-6 tablets daily for the past 3 months & is now out of her prescription for the past 24 hours.
- She presents to the clinic with tremors, severe nausea & is sweating profusely. She states she really needs her drugs!!!



# What is this?

- VB is a 25 yr old African American male with diabetic peripheral neuropathy.
- He has been prescribed methadone 5 mg PO BID + Morphine Sulfate IR 10 mg PO Q4H prn pain. (Rx for 60 tabs monthly)
- VB has called early each month (x4 months) for morphine & states the methadone doesn't work. Really wants to see if can get more morphine (2-3 tabs/dose effective) or if can switch to oxycodone.



# What is this?

- RY is a 29 yr old male Vietnamese American with post-herpetic neuralgia.
- He has been receiving morphine sulfate immediate release 10 mg every 4 hours prn pain for the past couple weeks & uses an average of 3 doses daily with good pain relief.
- He recently has been discharged & states he is now needing 5-6 doses daily for pain relief.



# Terminology Associated with Opioids

- Addiction
- Pseudo-addiction
- Physical Dependence
- Tolerance
- Pseudotolerance
- Substance Use Disorder



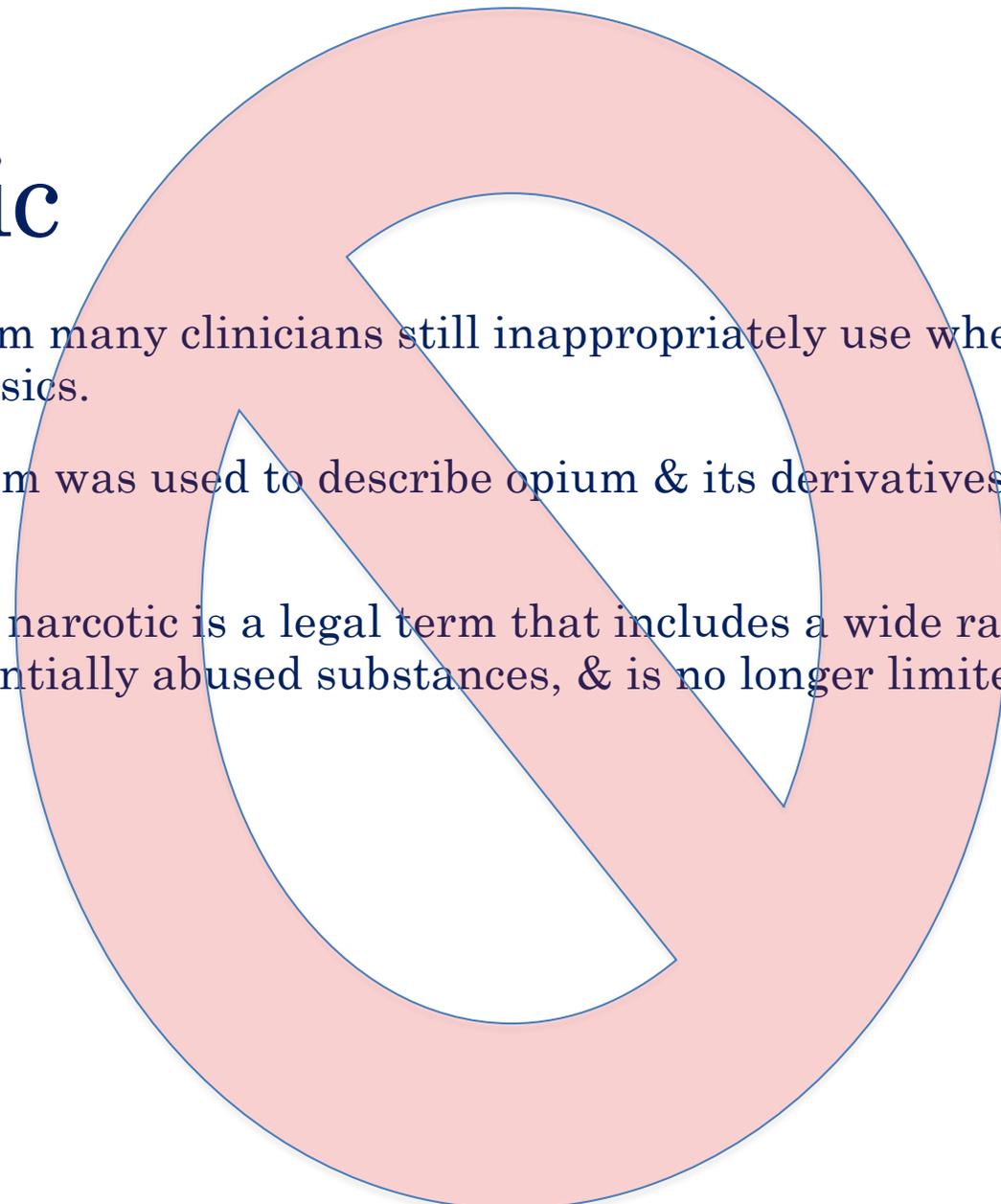
# Opioiphobia – Defined

The irrational fear by clinicians and/or patients related to appropriate opioid use for analgesic purposes. This phenomenon appears to be due in part to misunderstanding such terms as addiction, dependence & tolerance.



# Narcotic

- Narcotic – a term many clinicians still inappropriately use when they refer to opioid analgesics.
- This archaic term was used to describe opium & its derivatives in prior generations.
- Today the word narcotic is a legal term that includes a wide range of sedating & potentially abused substances, & is no longer limited to opioid analgesics.





# Addiction

Compulsive use of a substance resulting in

- physical
  - psychological, or
  - social harm
- to the user

*and*

Continued use despite of that harm



Rinaldi R et al. JAMA 1988;259:555-7.



# Addiction – Short Definition

Addiction is a primary, chronic disease of brain reward, motivation, memory & related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social & spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use & other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors & interpersonal relationships, & a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse & remission. Without treatment or engagement in recovery activities, addiction is progressive & can result in disability or premature death.

**American Society of Addiction Medicine  
Public Policy Statement – April 2011**



# Substance Use Disorder: DSM 5 Criteria

*Mild: 2-3 criteria; Moderate: 4-5 criteria; Severe:  $\geq 6$  criteria*

1. Taking the substance in larger amounts & for longer than intended
2. Wanting to cut down or quit substance use but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use substance
5. Repeatedly unable to carry out major obligations at work, school, or home due to substance use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by substance use



# Substance Use Disorder: DSM 5 Criteria

7. Stopping or reducing important social, occupational, or recreational activities due to substance use
8. Recurrent use of substance in physically hazardous situations
9. Consistent use of substance despite acknowledgment of persistent or recurrent physical or psychological difficulties from use
10. Tolerance defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount
  - *(Does not apply for diminished effect when used appropriately under medical supervision)*
11. Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal
  - *(Does not apply when used appropriately under medical supervision)*



# Physical Dependence

A physiological phenomenon characterized by:  
abstinence syndrome upon

- abrupt discontinuation
- substantial dose reduction
- administration of an antagonist

Occurs with steroids & many other drugs

- nearly universal with regularly scheduled opioids

**Rinaldi R et al. JAMA 1988;259:555-7.**



# Opioids & Dependence

- Abstinence syndrome can be induced
  - By administration of an antagonist
  - By marked dose reduction
- Time to onset variable
  - May occur as soon as after a few days of consistent dosing
  - Marked inter-patient variability
- Not clinically significant if abstinence syndrome avoided
- Does not independently cause or indicate addiction



# Tolerance

- Is tolerance a good thing, a bad thing or just a thing?





# Opioid Tolerance

## Tolerance

- Diminished drug effect from drug exposure
- Varied types: associative vs pharmacologic
- Tolerance to side effects is desirable
- Tolerance to analgesia is seldom a problem in the clinical setting

Tolerance rarely “drives” dose escalation

Tolerance does not cause addiction

# Types of Opioid Tolerance



## Tolerance to Analgesia

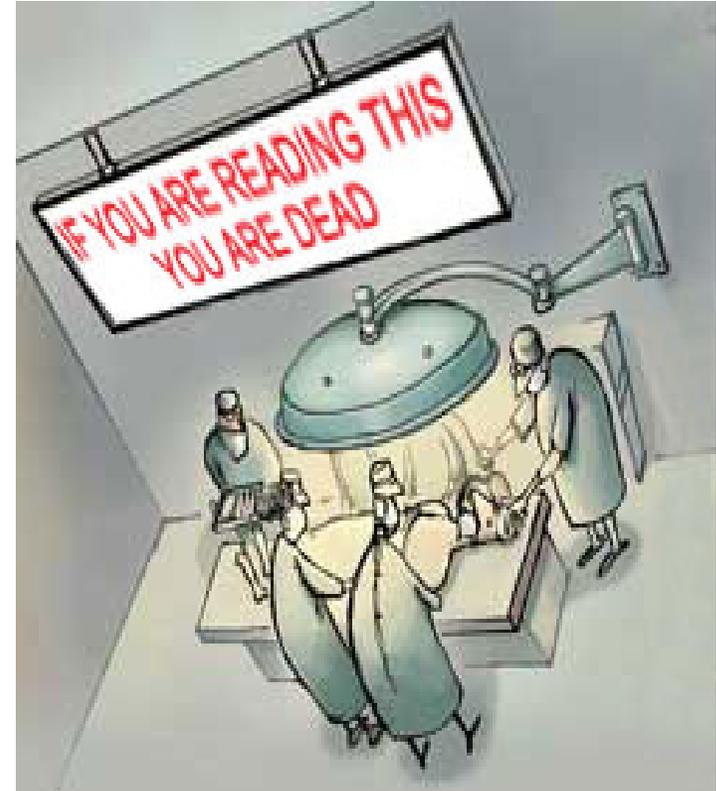
may occur in first days to weeks of therapy;  
Rare after pain relief achieved with consistent  
Dosing without increasing or new pathology.

## Tolerance to Respiratory Depression & Sedation

occurs predictably after 5-7 days of  
consistent opioid administration.

## Tolerance to Constipation

does not occur; scheduled stimulating  
laxatives are indicated with regularly  
scheduled opioids.



Jackson KC, Lipman AG. Opioid Analgesics. In Tollison, et al., editors. Practical Pain Management., 3<sup>rd</sup> Edition, Lippincott, Williams, & Wilkins, 2001.



# Pseudo-addiction

- Appropriate drug seeking behavior
  - Presents as aberrant drug-related behaviors
  - Driven by poor pain control
  - Patients demand dose increases/refills before scheduled
- Viscous cycle of anger, isolation, & avoidance leading to complete distrust
- Can be relieved by improved analgesia



# Pseudo-tolerance

- Progressive disease
- New pathology
- Excessive activity
- Noncompliance
- Medication changes
- Drug interaction
- Drug diversion
- Addiction



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# Aberrant Behaviors: Strategies

- Frequent visits & small quantities
  - 1 Prescriber & 1 Pharmacy
- NO replacements or early scripts
- Long-acting drugs with no rescue doses
  - No access to meds for breakthrough pain
- Use of random UDTs
- Coordination with sponsor, program, psychotherapist, others
- Consultation with addiction medicine specialist
- Prescription Drug Monitoring Programs (PDMP)
- Medication agreements



# Patient Care Agreements

- Widely used but not evidence based
- Reminder: opioids → one modality in multifaceted approach to achieving goals of therapy
- Detailed outline of procedures and expectations
- Prohibited behaviors, and grounds for taper or DC
- Limitations on prescriptions
- Emergency issues
- Refill and dose-adjustment procedures
- Exit strategy
- May contain elements of Informed Consent



# PDMP

- Pros

- Great Info on how patients obtain controlled substances
- Prescriber/Pharmacy shopping; reduction in fraudulent prescriptions
  - Intervention for patients with or developing dependencies
- Identify potential drug interactions
- Increased confidence in prescribing painkillers
- Capturing geographic trends and other data points to improve population health

- Cons

- Variability in Data
  - Dependent on input
  - Lag time for input
- Lack of state to state cooperation
- Take time to use
- Deter prescribers and pharmacists to involve use of appropriate controlled substances.



# PDMP Example

Rollins, Jenny K Female 12/20/1978 (37 yrs) (Community ID:3344223)  
 2985 Oxford Court, Columbus, MD 39701

Summary More Patient Information Patient Groups Patient Care Overview **Interstate PDMP** eHT HIE Worklist

Maryland Prescriptions											
Date Filled	Drug Name	Quantity Dispensed	Days Supply	Prescriber	Date Written	Pharmacy	Script #	Refills Remaining	Total Refills	Payment Method	State
11/03/2015	LORAZEPAM 1 MG TABLET	90		Who, John J	11/03/2015	YE OLDE APOTHECARY, LLC	528777	0	0	Commercial Insurance	MD
11/03/2015	HYDROMORPHONE 8 MG TABLET	90		Who, John J	11/03/2015	YE OLDE APOTHECARY, LLC	968825	0	0	Commercial Insurance	MD
11/03/2015	ALPRAZOLAM 1 MG TABLET	4		Who, John J	10/30/2015	YE OLDE APOTHECARY, LLC	295076	0	0	Commercial Insurance	MD
11/02/2015	AMPHETAMINE SALTS 20 MG TABLET	30		Who, John J	10/25/2015	YE OLDE APOTHECARY, LLC	7002350	0	0	Commercial Insurance	MD
11/02/2015	DEXTROAMP-AMPHET ER 20 MG CAP	90		Who, John J	10/25/2015	YE OLDE APOTHECARY, LLC	7002349-1	0	0	Commercial Insurance	MD
11/02/2015	DEXTROAMP-AMPHET ER 20 MG CAP	90		Who, John J	09/25/2015	YE OLDE APOTHECARY, LLC	7002349	0	0	Commercial Insurance	MD

Disclaimer: These are in-state prescriptions

### Out-of-State Prescriptions

No Out-of-State Prescriptions Found

Disclaimer: These are out-of-state prescriptions

Currently searching KS, MD



# Screening Tools for Opioids & Substance Misuse – Patient Reported

- ORT: Opioid Risk Tool
  - Simple 5 Question Tool
- SOAPP: Screener Assessment for Patients with Pain
  - Proprietary
    - <http://lwpainmanagement.com/uploads/3/1/9/2/3192998/soapp-r.pdf>
  - Patient Reported
  - Multiple versions (8, 14, & 24 Question Versions)
- COMM: Current Opioid Misuse Measure
  - Proprietary
    - <https://www.opioidprescribing.com/documents/09-comm-inflexxion.pdf>
  - Patient Reported
  - 17 Questions



Date \_\_\_\_\_

Patient Name \_\_\_\_\_

### OPIOID RISK TOOL

		Mark each box that applies	Base Score if Positive	Base Score if Negative
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder	[ ]	2	2
	Obsessive Compulsive Disorder Bipolar Schizophrenia			
	Depression	[ ]	1	1
<b>TOTAL</b>		[ ]		
<b>Total Score Risk Category</b>	<b>Low Risk 0 – 3</b>	<b>Moderate Risk 4 – 7</b>	<b>High Risk <math>\geq 8</math></b>	



#### Exhibit 2-14 SOAPP–R Questions

1. How often do you have mood swings?
2. How often have you felt a need for higher doses of medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can't handle them?
5. How often is there tension in the home?
6. How often have you counted pain pills to see how many are remaining?
7. How often have you been concerned that people will judge you for taking pain medication?
8. How often do you feel bored?
9. How often have you taken more pain medication than you were supposed to?
10. How often have you worried about being left alone?
11. How often have you felt a craving for medication?
12. How often have others expressed concern over your use of medication?
13. How often have any of your close friends had a problem with alcohol or drugs?
14. How often have others told you that you have a bad temper?
15. How often have you felt consumed by the need to get pain medication?
16. How often have you run out of pain medication early?
17. How often have others kept you from getting what you deserve?
18. How often, in your lifetime, have you had legal problems or been arrested?
19. How often have you attended an Alcoholics Anonymous or Narcotics Anonymous meeting?
20. How often have you been in an argument that was so out of control that someone got hurt?
21. How often have you been sexually abused?
22. How often have others suggested that you have a drug or alcohol problem?
23. How often have you had to borrow pain medications from your family or friends?
24. How often have you been treated for an alcohol or drug problem?

Reprinted from Butler et al., 2008. Validation of the revised screener and opioid assessment for patients with pain. *Journal of Pain*, 9, 360–372. Used with permission from Elsevier.



# Screening Tools for Opioids & Substance Misuse – Clinician Administered

- DIRE: Diagnosis, Intractability, Risk, and Efficacy
  - Clinician administered
  - 7 Factors
  - Scores < 13 indicate may not be suited to long-term opioid management
  - [http://www.emergingsolutionsinpain.com/content/tools/esp\\_9\\_instruments/pdf/DIRE\\_Score.pdf](http://www.emergingsolutionsinpain.com/content/tools/esp_9_instruments/pdf/DIRE_Score.pdf)
- PADT: The Pain Assessment and Documentation Tool
  - Clinician administered
  - Fairly comprehensive
  - <https://healthinsight.org/Internal/assets/SMART/PADT.pdf>
- CAGE-AID: CAGE Adapted to Include Drugs
  - Simple 4 Question Tool



Your Turn!

Think about the last patient you remember that you considered opioid therapy. Take a few minutes and complete the DIRE.

## DIRE Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right-hand column

SCORE	FACTOR	EXPLANATION
	<b>DIAGNOSIS</b>	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	<b>INTRACTABILITY</b>	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
<b>0</b>	<b>RISK</b>	<b>(R = Total of P+C+R+S below)</b>
	<b>Psychological</b>	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	<b>Chemical Health</b>	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of chemical dependence (CD) in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	<b>Reliability</b>	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	<b>Social Support</b>	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	<b>EFFICACY SCORE</b>	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

     **0**      **Total score = D + I + R + E**

**Score 7-13:** Not a suitable candidate for long-term opioid analgesia

**Score 14-21:** May be a good candidate for long-term opioid analgesia

### NOTES

A DIRE Score of  $\leq 13$  indicates that the patient may not be suited to long-term opioid pain management.

**Progress Note**  
**Pain Assessment and Documentation Tool (PADT™)**

Patient Name: \_\_\_\_\_ Record #: \_\_\_\_\_

Patient Stamp Here

Assessment Date: \_\_\_\_\_

**Current Analgesic Regimen**

Drug Name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

**Analgesia**

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)

\_\_\_\_\_

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?

Yes  No

5. Query to clinician: Is the patient's pain relief clinically significant?

Yes  No  Unsure

**Activities of Daily Living**

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.\* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Social relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sleep patterns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

**Progress Note**  
**Pain Assessment and Documentation Tool (PADT™)**

**Adverse Events**

1. Is patient experiencing any side effects from current pain reliever?  Yes  No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental cloudiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Potential Aberrant Drug-Related Behavior**

This section must be completed by the physician

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- Purposeful over-sedation
- Negative mood change
- Appears intoxicated
- Increasingly unkempt or impaired
- Involvement in car or other accident
- Requests frequent early renewals
- Increased dose without authorization
- Reports lost or stolen prescriptions
- Attempts to obtain prescriptions from other doctors
- Changes route of administration
- Uses pain medication in response to situational stressor
- Insists on certain medications by name
- Contact with street drug culture
- Abusing alcohol or illicit drugs
- Hoarding (ie, stockpiling) of medication
- Arrested by police
- Victim of abuse
- Other: \_\_\_\_\_

2. Patients overall severity of side effects?

None  Mild  Moderate  Severe

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy?  Yes  No  Unsure

Comments: \_\_\_\_\_

**Specific Analgesic Plan:**

- Continue present regimen
- Adjust dose of present analgesic
- Switch analgesics
- Add/Adjust concomitant therapy
- Discontinue/taper off opioid therapy

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Physicians Signature: \_\_\_\_\_

Provided as a service to the medical community by Janssen Pharmaceutica Products, L.P.



### CAGE-AID Questionnaire

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	1	1
2. Have people annoyed you by criticizing your drinking or drug use?	1	1
3. Have you ever felt bad or guilty about your drinking or drug use?	1	1
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	1	1

#### Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

#### Psychometric Properties

The CAGE-AID exhibited:	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

(Brown 1995)



# Tool Differentiation: Long-Term Opioid Therapy

## Assess Initiation

- ORT
- SOAPP

## Not Opioid Specific

- DIRE
- SISAP

## Assess Long-term Opioid Therapy

- ▶ COMM
- ▶ PADT

## Not Opioid Specific

- ▶ ABC: Addiction Behavior Checklist
- ▶ PDUQ-p: Prescription Drug Use Questionnaire - patients
- ▶ PMQ: Pain Medication Questionnaire



# CDC Opioid Guidelines Recommendation Highlights

## Assessing Risk & Addressing Harms of Opioid Use

### Recommendation 10: (Recommendation category: B; evidence type: 4)

- When prescribing opioids for chronic pain, clinicians should use urine drug testing (UDT) before starting opioid therapy & consider UDT urine **at least annually** to assess for prescribed medications as well as other controlled prescription drugs & illicit drugs.
- Clinicians should be familiar with the drugs included in UDT panels used in their practice & should understand how to interpret results for these drugs.
- Clinicians should not dismiss patients from care based on UDT result. This could have adverse consequences for patient safety, including missed opportunities to facilitate treatment for substance use disorder.



# UDT – WHY?

- Obtain objective data
  - analyze adherence
- Manage prescription drug use
  - Baseline prior to initiation
  - Ensure compliance with prescribed drug(s)
  - Identify use of non-prescribed drugs or illicit substances
- Help identify harmful drug interactions, misuse, abuse
- Advocate for patients
- Meet regulatory expectations
- Protect their practice



# UDT – WHO?

- Initiating chronic controlled substances (e.g. opioids)
- Patients already taking prescribed controlled substances (e.g. opioids) when they present for care
- Any time a major change in rational pharmacotherapy
- Resist full evaluation or presents with an unreliable/unavailable medical history
- Requests a specific controlled drug, even though it might be a valid request
- Display aberrant behaviors
- Exhibits mental health problems
- Uses alcohol or tobacco
- History of or exhibiting a substance use disorder

<https://www.practicalpainmanagement.com/resource-centers/quest-monitoring/who-monitor>

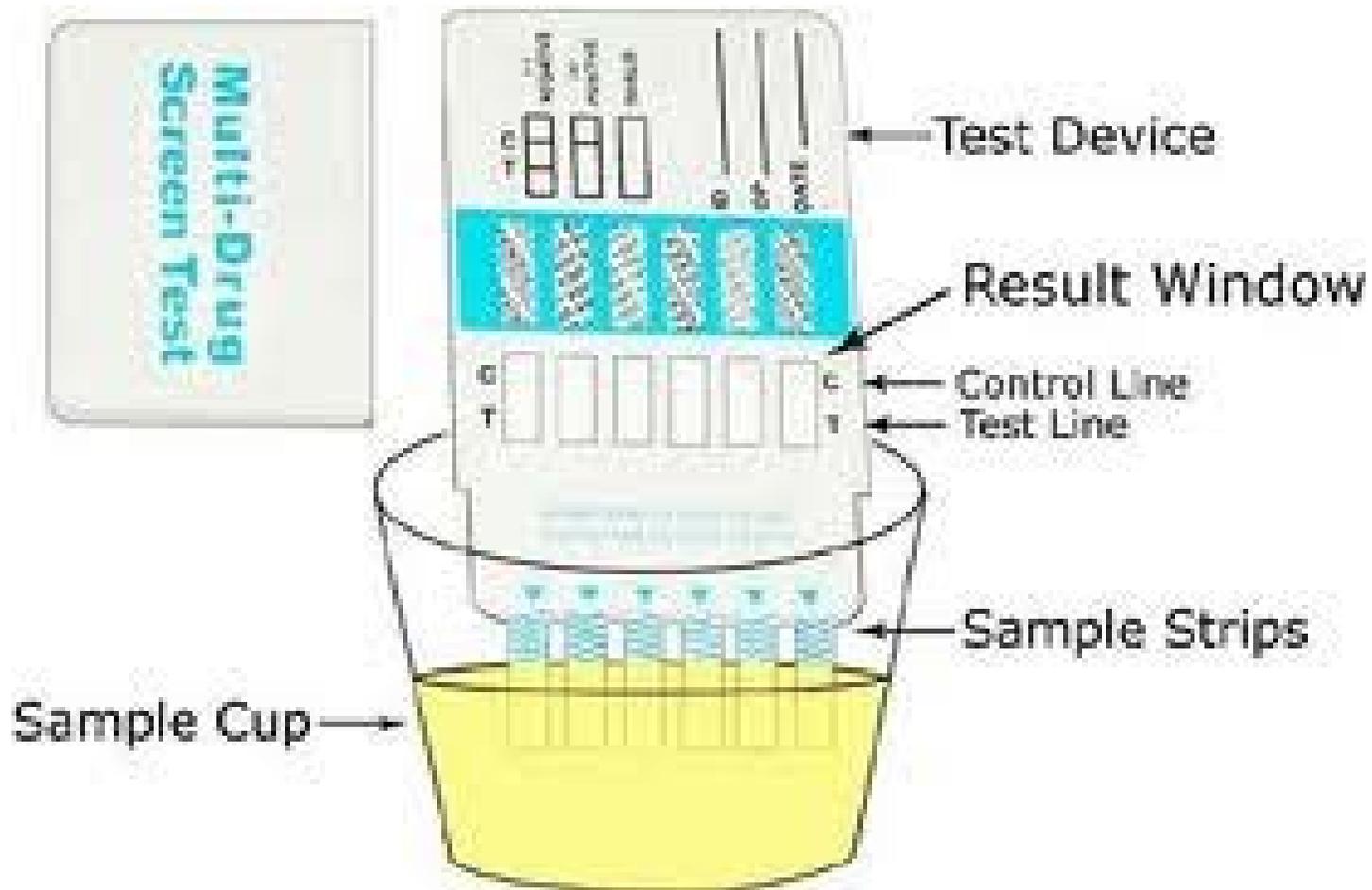


# UDT – Presumptive Drug Monitoring

- Primarily immunoassay
- Point of Care testing
- Qualitative data
  - Negative or positive results
  - Cannot distinguish true positive from false positive
- Quick
- Can screen multiple agents at one time



# Example of Point of Care UDT





# The Federal 5

**Table 1. Initial cutoff concentrations used during federally-regulated testing**

Drug	Cutoff concentration (ng/mL)
Marijuana metabolites	50
Cocaine metabolites	300
Opiate metabolites	2000
Phencyclidine	25
Amphetamine	1000

49CFR§40.29. 1994, modified 1998.



# Opiate Screens & UDT?

- Opiates are naturally occurring opioids
  - Codeine & morphine
- Rarely sensitive for semi-synthetic agents (e.g. oxycodone)
- To determine methadone (a synthetic opioid) a specific assay is required



# Pitfalls of UDT for Compliance

- Not actually using the medication
- Relationship of timing of last dose of medication to the UDT
- Rapid excreter or metabolizer of the substance
- pH of urine
- UDT not sensitive enough
- Clerical errors caused to a positive UDT to be reported as negative



# Definitive Drug Monitoring

- Quantitative
- Determines specific drugs and metabolites
- Can confirm presumptive results
- Can rule out false results
- Increased cost and time



# Opioid Storage & Disposal

- Communication is VITAL!
- Keep in cool, dry place.
- This should be a safe place – preferably locked – where children and visitors cannot access these medications.
- Use take back programs when available!
- If not, FDA and DEA recommend different approaches.

## DEA (EPA)

- Mix with undesirable substances such as coffee grounds or cat litter.
- Seal in disposable container or bag.
- Throw in garbage.
- Do not Flush
- Remove Info from Rx Label





# Opioid Disposal – FDA Flushables

<b>Benzhydrocodone/ Acetaminophen</b>	<a href="#">Apadaz</a>
<b>Buprenorphine</b>	<a href="#">Belbuca</a> <a href="#">Bunavail</a> <a href="#">Butrans</a> <a href="#">Suboxone</a> <a href="#">Subutex</a> <a href="#">Zubsolv</a>
<b>Fentanyl</b>	<a href="#">Abstral</a> <a href="#">Actiq</a> <a href="#">Duragesic</a> <a href="#">Fentora</a> <a href="#">Onsolis</a>
<b>Diazepam</b>	<a href="#">Diastat</a> <a href="#">Diastat AcuDial rectal gel</a>
<b>Hydrocodone</b>	<a href="#">Hysingla ER</a> <a href="#">Norco</a> <a href="#">Vicoprofen</a> <a href="#">Zohydro ER</a>
<b>Hydromorphone</b>	<a href="#">Dilaudid</a> <a href="#">Exalgo</a>
<b>Meperidine</b>	<a href="#">Demerol</a>
<b>Methadone</b>	<a href="#">Dolophine</a> <a href="#">Methadose</a>
<b>Methylphenidate</b>	<a href="#">Daytrana transdermal patch system</a>
<b>Morphine</b>	<a href="#">Arymo ER</a> <a href="#">Embeda</a> <a href="#">Kadian</a> <a href="#">Morphabond ER</a> <a href="#">MS Contin</a> <a href="#">Avinza</a>
<b>Oxycodone</b>	<a href="#">Combunox</a> <a href="#">Oxaydo</a> <a href="#">OxyContin</a> <a href="#">Percocet</a> <a href="#">Percodan</a> <a href="#">Roxicodone</a> <a href="#">Targiniq ER</a> <a href="#">Xartemis XR</a> <a href="#">Xtampza ER</a> <a href="#">Roxybond</a>
<b>Oxymorphone</b>	<a href="#">Opana</a> <a href="#">Opana ER</a>
<b>Tapentadol</b>	<a href="#">Nucynta</a> <a href="#">Nucynta ER</a>
<b>Sodium Oxybate</b>	<a href="#">Xyrem oral solution</a>

