Nebraska Medicaid

DUR Matters

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Overview: CDC Guideline for Prescribing Opioids for Chronic Pain

Written by Stephanie Nitz, PharmD Candidate, University of Nebraska Medical Center College of Pharmacy

On March 15, 2016, the Center for Disease Control (CDC) published an updated guideline for prescribing opioids for patients with chronic pain. The guideline was created on the foundation of a systematic review of evidence along with contribution from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee.

The guideline focuses on three main areas:

1. When to initiate or continue opioids for chronic pain,
2. Opioid selection, dosage, duration, follow-up, and discontinuation, and
3. Assessing risk and addressing harms of opioid use.

The guideline is intended for patients aged 18 years or older with chronic pain, excluding palliative and end-of-life care.

Background

The CDC estimates that 20% of patients with non-cancer pain receive an opioid prescription. Prescriptions for opioids have increased 7.3% per person from 2007 to 2012. The increased rate in prescriptions written for opioids mainly occurs from providers in family practice, general practice, and internal medicine instead of specialists. The CDC defines *chronic pain* as pain lasting for more than three months.

There are serious risks with the use of opioid pain medications such as overdose and opioid use disorder. In the past 15 years, more than 165,000 people in the United States have died from opioid overdoses and the number continues to increase each year.

Primary Clinical Questions and Focus Areas

Currently, there are no studies available to determine the effectiveness of opioid therapy versus placebo. Nor has there been an evaluation of opioid versus non-opioid effectiveness at managing pain when the duration is greater than 1 year. Comparisons between extended-release/long-acting (ER/LA) and immediate release opioids for titrating patients to a steady pain control, lack sufficient evidence to determine adequate effectiveness.

When comparing the benefits and harms of opioid therapy, it is vital to determine a balance. One of the biggest concerns with opioid therapy is that long-term opioid therapy is associated with an increased risk of developing abuse. Factors associated with higher risk for abuse include previous history of abuse, younger age of patient, diagnosis of depression, and current or previous use of psychotropic medications. ER/LA opioids have been linked with significantly higher amounts of the average daily opioid dosage

than with the use of the immediate-release opioids. ER/LA opioids have additionally been associated with increased overdose cases due to methadone. Opioid-related overdose risk is dependent on the dose prescribed. Higher opioid doses are associated with an increased overdose risk. Concomitantly prescribed opioids and benzodiazepines result in a higher risk of fatal overdose. Tolerance to opioids can be present in many patients, and in cases where patients do not experience clinically meaningful relief of pain within 1 month, opioid therapy should be discontinued as they are unlikely to achieve relief of pain long-term. Risk for harm is greatest in patients with sleep-disorder breathing problems (sleep-apnea), adults 65 years or older, those with renal or hepatic insufficiency, patients who experience depression or other mental health conditions, individuals with alcohol or other substance abuse disorders, or in women who are pregnant.

According to the CDC Guideline, there is an inconsistency of instruments for predicting risk of opioid overdose, addiction, abuse, or misuse. Due to the difficulty in predicting these risks, nonpharmacologic and non-opioid treatments should be considered prior to prescribing an opioid. Several nonpharmacologic treatments have demonstrated effectiveness in managing chronic pain. These nonpharmacologic therapies include exercise therapy and the combination of psychological-based approaches with exercises. Another effective way to achieve pain management is through non-opioid therapy such as non-steroidal anti-inflammatories (NSAIDs), acetaminophen, certain anticonvulsants, particular antidepressants (tricyclic antidepressants or serotonin-norepinephrine reuptake inhibitors (SNRIs)). The recommended first line agent for osteoarthritis or low back pain is acetaminophen or NSAIDs. The recommended first line agent for neuropathic pain is either an anticonvulsant (gabapentin or pregabalin), tricyclic antidepressant, or an SNRI.

Guideline Focus: When to Initiate or Continue Opioids for Chronic Pain

The preferred therapy for chronic pain management are nonpharmacologic and non-opioid pharmacologic options. Opioid medications should only be considered if the anticipated benefits of pain relief and increased function outweigh the risk to the patient. If an opioid is prescribed, it should be used concomitantly with nonpharmacologic and non-opioid therapy.

The CDC recommends that clinicians establish treatment goals with patients prior to initiating opioid therapy. Clinicians should also discuss how therapy will be discontinued if the risks outweigh the benefits. Opioid therapy should only be continued if a clinically meaningful improvement in pain and function has been established and these benefits outweigh the risk to patient safety. A discussion between clinicians and patients is preferred before starting and sporadically throughout opioid therapy. The discussion should include known risks and realistic benefits of using an opioid and should also state that the clinician is responsible for managing therapy.

Guideline Focus: Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

Clinicians are encouraged to prescribe immediate-release over extended-release/long-acting (ER/LA) opioids when initiating opioid therapy.

The lowest effective dose to manage pain is recommended in the CDC Guideline and caution is advised when prescribing opioids regardless of dosage. Clinicians should cautiously reassess the specific benefits and risks of each when increasing opioid dosage to ≥ 50 morphine milligram equivalents (MME)/day. Avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day. Morphine milligram equivalents can be calculated online at: *http://www.nyc.gov/html/doh/html/mental/MME.html*.

Treatment of acute pain frequently leads to

the development of long-term opioid use. The guidelines recommend that if opioids are selected for management of acute pain, the lowest effective dose of immediate-release opioids should be prescribed, and in no greater quantity than needed for the estimated duration of pain that is severe enough to require opioids. A sufficient duration is 3 days or less. A duration of greater than 7 days will seldom be necessary.

The benefit to risk should be evaluated with patients within 1 to 4 weeks of both initiating opioid therapy or of dose escalation. For patients on continued opioid therapy, the benefits and harms should be evaluated at least every 3 months. In either case, if the benefits do not outweigh harms of continued opioid therapy, other therapies should be considered and opioids are recommended to be tapered to lower dosages or discontinuation.

Guideline Focus: Assessing Risk and Addressing Harms of Opioid Use

Risk factors for opioid-related harms should be assessed prior to starting and randomly throughout opioid therapy. An opioid management plan is advised to include strategies to mitigate risk such as possibly offering naloxone to patients at increased risk for opioid overdose including previous history of overdose, substance use disorder, individuals on higher opioid dosage (≥ 50 MME/day), or those concurrently prescribed a benzodiazepine.

The CDC Guideline encourages practitioners to review a patient's history of controlled substance prescriptions by using the State's prescription drug monitoring program (PDMP) data to conclude whether a patient is receiving opioids or currently on a dangerous combination of medications that increase the risk for overdose.

LB 471 is legislation that was passed to update the State PDMP. As of January 1, 2017, dispensers will be required to report all dispensed controlled substances. Dispensers and prescribers will have access to the PDMP at no cost. The CDC Guideline recommends reviewing the PDMP either before every prescription is written or every 3 months.

The CDC Guideline also encourages urine drug testing prior to starting a patient on opioids for chronic pain. Testing is recommended to be completed annually to measure prescribed medications in addition to other controlled prescription and illicit drugs.

According to the CDC Guideline, concurrent use of benzodiazepines and opioid pain medications should be avoided whenever possible.

The CDC Guideline states for patients with opioid use disorder, evidence-based treatment such as medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies, should be offered or arranged by the patient's clinician.

Conclusion

The DUR Board encourages practitioners to consider the CDC Guideline in the responsible treatment of Nebraska Medicaid patients.

CONTACT INFORMATION

DUR Director
Marcia Mueting, PharmD, RP
6221 S 58th Street, Suite A, Lincoln, NE 68516
Phone (402) 420-1500
Email dur@npharm.org

Nebraska Medicaid
Department of Health & Human Services
PO Box 95026, Lincoln, NE 68509-5026
Phone (402) 471-9029
Email dhhs.MedicaidPharmacyunit@nebraska.gov