Managing Opioids Safely and within Vermont Rules

SUMMARY FOR MEDICAL AND DENTAL PRESCRIBERS

Recommend Non-Opioid and Non-Pharmacological Treatment

- Nonsteroidal anti-inflammatory drugs (NSAIDs) and/or acetaminophen
- Acupuncture
- Chiropractic
- Physical therapy
- Yoga

Only prescribe opioids if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, combine with non-opioid alternatives.

Query the Vermont Prescription Monitoring System (VPMS)*

First-time Prescriptions:

- Prior to writing a first opioid prescription for greater than 10 pills (e.g. opioids, tramadol)
- Prior to writing a first prescription for a benzodiazepine, buprenorphine, or methadone
- Prior to starting a patient on a chronic opioid (90+ days) for non-palliative therapy

Re-evaluation: At least annually (at least twice annually for buprenorphine)

- Centers for Disease Control (CDC) recommendation: every prescription, or at least every 90 days

Replacement: Prior to writing a replacement (e.g. lost, stolen) of any scheduled II-IV controlled substance

Provide Patient Education and Obtain Informed Consent

Discuss Risks *in-person* with the patient or legal representative regarding potential side effects, risks of dependence and overdose, alternative treatments, appropriate tapering, and safe storage and disposal of opioids

- CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

Provide Written Patient Education: Use the Vermont Department of Health (VDH) Opioid Patient Information Sheet or a handout that contains all of the same information at a 5th grade reading level or lower. www.healthvermont.gov/sites/default/files/documents/pdf/adap_opioid_patient_information.pdf

Obtain a Signed Informed Consent document from the patient or legal representative that contains all of the required elements stated in the Opioid Prescribing Rule, section 4.3.3.1.

Use Available Resources: The Opioid Patient Information Sheet and an example informed consent document are available in multiple languages and may be found online at: www.healthvermont.gov/news-information-resources/translated-information/language.
Additional resources may be found at: www.healthvermont.gov/alcohol-drugs/professionals/help-me-stay-informed and www.cdc.gov/drugoverdose

Prescribe Nasal Naloxone when Indicated

High Dose: 90+ Morphine Milligram Equivalent (MME) per day

Concomitant benzodiazepine: Patients prescribed both an opioid and a benzodiazepine (CDC recommends avoiding these combinations)

CDC: History of overdose, history of substance use disorder, 50+ MME per day prescriptions

Arrange for Evidence-based Treatment for Patients with Opioid Use Disorder

CDC: Offer evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

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** Prescriber registration with the VPMS is mandatory. For the complete rules, visit the Vermont Prescription Monitoring System Rule (7/1/17) and Rule Governing the Prescribing of Opioids for Pain (3/1/19) found at www.healthvermont.gov. CDC Guidelines: Dowell D, et al. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. JAMA. 2016 Apr 19;315(15):1624-45. PMID: 26977696*

Complete Continuing Education Requirements

Complete at least two hours of continuing education for each licensing period on the topic of Controlled Substances. Visit vtad.org, your licensing board, or check with your professional society for information and available courses.

Prescribe the Lowest Effective Dose of Immediate-release Opioids

- For acute pain, prescribe 0-5 days of therapy. See table below.
- Prescription limits only apply to first prescriptions for opioid naïve patients
- Include the maximum daily dose or a "not to exceed" equivalent on the prescription

Evaluate Patients Regularly Using Best Practices

- Reevaluate patients (and document) at least every 90 days (both VT Rules and CDC)
- Calculate MME. Consider 50-89 daily MME a "yellow light" and 90+ MME a "flashing red light."
- Use evidence-based tools to evaluate pain and function (e.g. PEG), and potential for abuse and diversion (e.g. COMM)
- CDC: A 30% improvement in PEG score is clinically meaningful. If benefits do not outweigh risks, taper opioids.
- CDC: Use urine drug screening prior to initiating opioids. Rescreen at least annually.

Document, Document, Document

- Medical evaluation, including physical and functional exams and assessment of comorbidities
- Diagnoses which support the use of opioids for chronic pain and whether to continue opioids
- Individual benefits and risks, using evidence-based tools (e.g. RAPID3, SOAPP, COMM)
- Non-opioid and non-pharmacological treatments tried and trial use of the opioid
- VPMS query
- Patient discussion about the risk of overdose, including any precautions the patient should take
- VDH Opioid Patient Information Sheet provided
- That the prescriber has asked the patient if he or she is currently, or has recently been, dispensed methadone or buprenorphine or prescribed and taken any other controlled substance
- Signed Controlled Substance Treatment Agreement: update at least annually
- Acknowledgement that a violation of the agreement will result in a re-evaluation of the therapy plan

Opioid Prescription Limits for Acute Pain (Prescribe Immediate-Release Formulations)

PEDIATRICS		
Consider discussing the benefits and risks of prescribing an opioid to a pediatric patient with a colleague or specialist. Use extreme caution. Calculate dose for patient's age and body weight. Consider the indication, pain severity, and alternative therapies. Limit prescriptions to 3 days or less with an average MME of 24 or less. Do not write additional prescriptions without evaluating the patient.		
ADULTS	**Average Daily**	**Total RX**
MINOR PAIN (Examples: sprains, headaches, tooth extraction)	No opioids	No opioids
MODERATE PAIN (Examples: non-compounded bone fractures, soft tissue surgery, most outpatient laparoscopic surgery)		
Hydrocodone 5mg	MME: 24 / 0-4 tablets	0-5 days / 0-20 tablets
Oxycodone 5mg	MME: 24 / 0-3 tablets	0-5 days / 0-15 tablets
SEVERE PAIN (Examples: non-laparoscopic surgery, joint replacement, compound fractures)		
Hydrocodone 5mg	MME: 32 / 0-6 tablets	0-5 days / 0-30 tablets
Oxycodone 5mg	MME: 32 / 0-4 tablets	0-5 days / 0-20 tablets

Extreme pain (beyond severe) in adults is limited to a 7 day max with a 350 MME max. This should be rare. Prescribing outside of this table (i.e. exceptions) must be clearly documented. For the complete rules, visit the Rule Governing the Prescribing of Opioids for Pain (3/1/19) found at www.healthvermont.gov. CDC Guidelines: Dowell D, et al. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. 2016 Apr 19;315(15):1624-45. PMID: 26977696