# Managing Opioids Safely and within Vermont Rules

**SUMMARY FOR PRIMARY CARE PROVIDERS**

## Recommend Non-Opioid and Non-Pharmacological Treatment

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

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 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

- Discussion of risks, including side effects, risks of dependence and overdose, alternative treatments, appropriate tapering and safe storage and disposal
- Provide patient with the Vermont Department of Health (VDH) Patient Education handout
- Obtain signed informed consent, even for acute prescriptions
- VDH education resources: www.healthvermont.gov/alcohol-drugs/professionals/resources-patients-and-providers
- CDC education resources: www.cdc.gov/drugoverdose
- CDC: Establish realistic treatment goals for pain and function and establish patient and clinician responsibilities for managing therapy, including when to discontinue therapy

## 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 co-prescribing of opioids and benzodiazepines
- 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

## 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, vtmd.org/cme-courses, or check with your professional society for available courses.

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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 (7/1/17) 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*

## Prescribe the Lowest Effective Dose of Immediate-release Opioids

- For acute pain, prescribe 0-5 days of therapy. *See table below.*
- Include the maximum daily dose or a "not to exceed" equivalent on the prescription
- CDC: Prescribe immediate-release formulations when initiating opioids for chronic pain

## Evaluate Patients Regularly Using Best Practices

- Reevaluate patients (and document) at least every 90 days (both VT Rules and CDC)
- CDC: If benefits do not outweigh harms, taper opioids
- CDC: Use urine drug screening prior to initiating opioids. Rescreen at least annually.
- Calculate MME. Consider 50-89 daily MME a "yellow light" and 90+ MME a "red light."
- Use evidence-based tools to reevaluate adherence to the pain management therapy plan, functional goals (e.g. RAPID3), and potential for abuse and diversion (e.g. 5As, SOAPP, COMM)

## Document, Document, Document

- Medical evaluation, including physical and functional exams and assessment of comorbidities
- Diagnosis 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, 5As, SOAPP, COMM)
- Non-opioid and non-pharmacological treatments tried and trial use of the opioid
- VPMS query
- VDH Patient Education handout 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
- Patient discussion about the risk of overdose, including any precautions the patient should take
- *Signed Controlled Substance Treatment Agreement and Informed Consent*: 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**<br>Examples: Sprains, headaches, dental pain | No opioids | No opioids |
| **MODERATE PAIN**<br>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**<br>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 in primary care. 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 (7/1/17) 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*